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

CERTIFIED MAIL

JUL 05 2016

West Virginia United Health Systems
Nancy Repine, Assistant Vice President
Finance Planning & Reimbursement
3040 University Avenue
Morgantown, WV 26505

RE: United Hospital Center, Provider No. 51-0006, FYE 12/31/2010, Case No. 15-3328

Dear Ms. Repine:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in order to schedule 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 issue are set forth below.

Pertinent Facts:

The Provider filed an individual appeal on September 11, 2015, which included the following issues:

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

On May 25, 2016, the Provider authorized Quality Reimbursement Services, Inc. (QRS) to transfer various issues to group appeals. On May 31, 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 WVUHS/QRS group appeals."

Board Determination:

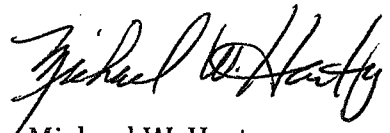
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 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 it was filed as a protested item (Adj. 19) and there were adjustments to the SSI percentage (Adj. 20 & 26), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also 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 have been 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 15-3328 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: Laurie Polson, Appeals Lead, Palmetto GBA c/o National Government Services, Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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JUL 06 2016

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RE: Pomerado Hospital
Provider No.: 05-0636
FYE: 6/30/09
PRRB Case No.: 14-0837

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 jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on November 18, 2013, based on a Notice of Program Reimbursement ("NPR") dated May 23, 2013. The hearing request included seven issues[1], four of which were subsequently transferred to group appeals and one of which was withdrawn. Two issues remain in the appeal as follows:

- Issue No. 1B – Outlier Payments and
- Issue No. 2 – Medicare Disproportionate Share Hospital (DSH) Payments – Medicaid Eligible Days

The Medicare Contractor submitted a jurisdictional challenge on Issue No. 1B on May 5, 2015.[2] The Provider filed a responsive brief on May 9, 2015.

Medicare Contractor's Position

The Medicare Contractor explains that the Provider disputes the outlier payments because they did not result in an aggregate national outlier payment of at least five percent of the total Prospective Payment System ("PPS") payment. The issue has been described as whether the Centers for Medicare and

[1] The Provider's hearing request listed six issues; Issue No. 1 actually contained two issues, bringing the total to seven.
[2] The Medicare Contractor also filed a jurisdictional challenge on Issue No. 6 – Medicare Disproportionate Share Hospital (DSH) Payments – SSI MMA Section 951 Applicable to SSI Ratio Issued March 16, 2012, however the issue was transferred to Case No. 15-2582GC – GNP/Palomar Health 2009 Medicare DSH Payments – SSI Ratio MMA Section 951 so it will be addressed in the group appeal.

Medicaid Services ("CMS") underpaid the Provider the required five percent outlier payments by establishing higher than necessary fixed loss thresholds used to calculate the number of cases that qualify for and the amount of outlier payments.[3]

The Medicare Contractor contends that it did not make an adjustment to the contested outlier reimbursement. As such, the Provider is not able to demonstrate that it meets the dissatisfaction requirement. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the outlier reimbursement now in question. There was no audit adjustment, so the Provider is dissatisfied with its own reporting of the contested outlier reimbursement, not the Medicare Contractor's determination. Additionally, the Provider also failed to preserve its right to claim dissatisfaction by including the reimbursement impact of the contested outlier payments as a Protested Amount on its filed cost report.[4]

Provider's Position

The Provider contends that the Medicare Contractor posted adjustments to the Provider's items of cost claimed in the as-filed cost report which satisfy the criteria of dissatisfaction at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a). The Provider states that the Medicare Contractor made an audit adjustment that revised the as-filed Medicare outlier payments from $0 to $707,239 per audit adjustment number 21, therefore, the Provider is afforded a right to appeal the outlier payments based on this audit adjustment.[5]

The Provider explains that the Medicare Contractor cited 42 C.F.R. § 412.110 as the Medicare regulations to support their audit adjustments. As set forth in 42 C.F.R. § 412.110, Medicare's total payment for inpatient hospital services will equal the sum of the payments listed in § 412.112 through § 412.115. The total payments in § 412.112 include a provision that appropriate outlier payment amounts must be determined under subpart F – § 412.80, § 412.82, § 412.84 and § 412.86. These cited Medicare regulations outline the methods in establishing the outlier thresholds. The Provider contends that its appeal of the outlier payments is in accordance with these Medicare regulations in order to account for the proper calculation of the outlier threshold.[6]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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 jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim

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[3] Medicare Contractor's Jurisdictional Challenge at 2.
[4] *Id.* at 3.
[5] Provider's jurisdictional response at 3.
[6] *Id.*

sissatisfaction.....by.....[i]ncluding a claim for specific item(s) on its cost report...or...self-disallowing the specific item(s) by.....filing a cost report under protest.....[7]

The Board concludes that it does not have jurisdiction over the Outlier Payments issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

The Provider states that adjustments made by the Contractor regarding its outlier payments were covered by Adjustment No. 21. Upon review of this adjustment, the Board finds that the Medicare contractor did make a PS&R adjustment to the outliers line. However, that adjustment would have only been to adjust the paid outliers PS&R and would not have specifically adjusted the contested Outlier Payments that are under appeal. The Provider indicates that it was under-reimbursed for outlier claims. The Board finds that the Provider could have computed an estimate and included them as a protested amount, but failed to do so. Those payments were not claimed and therefore were not adjusted by the Medicare contractor as required by 42 C.F.R. §405.1835(a)(1)(i) (2009) and 42 C.F.R. §405.1835(a)(1)(ii).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE June 30, 2009; therefore, any self-disallowed items are required to be protested.

The Board finds that the Provider did file a Protested Amount of $10,000 on line 30 of Worksheet A of its as-filed cost report that was removed in Adjustment No. 20. However, the Board finds that there is no evidence in the record detailing the composition of the Protested Amount. Absent that evidence, the Board concludes that the Provider failed to file the Outlier Payments issue under protest. Therefore, the Provider failed to preserve its rights to claim dissatisfaction.

The Board concludes that it does not have jurisdiction over the Outlier Payments issue as there was no adjustment related to the issue and the issue was not properly protested, and dismisses the issue from the appeal. The Medicaid Eligible Days issue remains in the appeal. This case is scheduled for a live hearing on July 14, 2016.

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

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

FOR THE BOARD

Charlotte Benson for

Michael W. Harty

[7] 42 C.F.R. § 405.1835(a).

Chairman

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

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Refer to:
15-1533GC
Certified Mail

JUL 06 2016

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RE: **PRRB Own Motion Expedited Judicial Review Determination**
HRS Prime Healthcare FFY 2015 2 Midnight CIRP Group
Provider Nos. Various
FFY 2015
PRRB Case No. 15-1533GC

Dear Mses. Goron and Alcantara:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' December 4, 2015 response to the Board's November 6, 2015 notice that it was considering expedited judicial review ("EJR") on its own motion. The Providers' letter indicated that the issue under appeal was suitable for EJR. The Board's decision regarding EJR on its own motion is set forth below.

Issue Under Appeal

> Whether the provision in the Fiscal Year 2015 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that adjusts the published standardized amount and imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014 - 2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of [the Secretary].[1]

Statutory and Regulatory Background

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

[1] Providers' February 16, 2015 Hearing Request, Tab 2, Statement of Issue.
[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).

in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

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 benchmark that inpatient admissions are generally reasonable and

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[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

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]

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013).
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.
[14] *Id.* at 50,944.

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 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 2015 period.[19]

Providers' Position

The Providers contend that the provision of the final rule imposing a 0.2 percent decrease in the IPPS rates was an agency action conducted "without observance of procedure required by law" and should be set aside.[20] Pursuant to 5 U.S.C. § 706(2)(A), an agency action that is "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law" should also be set aside. The Providers believe that 42 U.S.C. § 1395ww does not provide authority for the Secretary to institute an across-the-board payment cut in the IPPS payment rates.[21]

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[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[20] Providers' February 16, 2015 Hearing Request, Tab 2, Statement of Issue.
[21] *Id.*

The Providers do not believe the Board has the authority to declare the 0.2 percent decrease to IPPS rates invalid because 42 C.F.R. § 405.1867 requires that the Board comply will all of the provisions of Title XVIII of the Social Security Act and the regulations thereunder. Since the Board lacks the authority to decide whether the final IPPS rule is procedurally valid, the Providers assert that EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' request for hearing and comments responsive to the Board's own motion EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 22, 2014 Federal Register[22] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[23] Consequently, the Board has determined that it has jurisdiction over Providers' appeal. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR on the Board's own motion is appropriate for the issue under dispute in this group appeal.

The Board finds that:

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

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

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

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

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

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

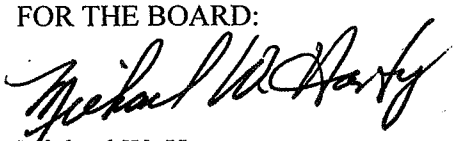
[23] *See* 42 C.F.R. § 405.1837(a)(3).

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services

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Refer to: 15-0100, 15-0099

JUL 06 2016

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RE: **PRRB Own Motion Expedited Judicial Review Determination**
Olean General Hospital, Provider No. 33-0103, FFY 2015, PRRB
Case No. 15-0100
Bradford Hospital, Provider No. 39-0118, FFY 2015, PRRB
Case No. 15-0099

Dear Messrs. Blumberg and Snyder and Ms. VanArsdale:

The Provider Reimbursement Review Board (Board) sent the Providers notice on September 18, 2015, that it was considering expedited judicial review ("EJR") on its own motion and asked for the parties' comments. There was no response from either party to this notice. The Board's decision regarding EJR on its own motion is set forth below.

Issue Under Appeal

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

Statutory and Regulatory Background

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

[1] Providers' October 7, 2014 Hearing Requests, Tab 2.

("OPPS") rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

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

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

observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges ("ALJs"). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that 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

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[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
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hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on 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

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[13] *Id.* at 50,927.
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[15] *Id.*
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encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[19]

Providers' Position

In their hearing requests,[20] the Providers note that the Secretary maintains that she is relying on 42 U.S.C. § 1395ww(d)(5)(I)(i) which states:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

The Providers assert that this authority does not authorize CMS to implement the IPPS rate reduction. It points out that CMS has rarely exercised this authority, and on the occasions it has done so, the purpose was to more fully or appropriately implement a recent Congressional requirement. It has never been exercised as broadly as the IPPS rate reduction.

The Providers further contend that, even if this authority is applicable, this authority requires CMS [sic the Secretary] to "provide by regulation" the IPPS rate reduction.[21] Instead, CMS merely discussed the IPPS rate reduction in the preamble to the IPPS final rule.[22] As a result, even if CMS claims it is authorized to implement the IPPS rate reduction under 42 U.S.C. § 1395ww(d)(5)(I)(i), CMS failed to provide for the IPPS rate reduction by regulation, which the Providers believe makes it invalid. Further, the Providers assert, the IPPS rate reduction violates the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*

In addition, the Providers contend that CMS is not under a statutory requirement to make budget-neutrality adjustments for changes in coverage decisions or service volume. The IPPS rate reduction is, in effect, a coverage decision, or at a minimum a clarification of policy, that CMS

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[20] Providers' October 7, 2014 Hearing Requests, Tab 2.
[21] *See Int'l Union, United Mine Workers of Am.v. Mine Safety & Health Admin.*, 68 Fed. Appx. 205, 206 (D.C. Cir. 2003) (unpublished per curiam).
[22] *See* 78 Fed. Reg. at 50,953-54.

believes would result in an increase in volume. As a result, inpatient hospital services would be covered under Medicare Part A if the physician expects that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only. CMS purports to have determined that this coverage decision would lead to a net increase of 40,000 inpatient hospital admissions. The Providers argue that what CMS has failed to recognize is that the 2-midnight rule does not increase payment rates for inpatient cases, which are made budget neutral as part of the annual rate adjustment process. Moreover, to apply budget neutrality to coverage decisions or volume changes would violate the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, the IPPS payments adjust automatically for both service mix and volume of hospital admissions, which vary from year to year. CMS has never made budget-neutrality adjustments for these changes.

The Providers also argue that CMS [sic the Secretary] failed to adequately respond to and take into account comments challenging the actuarial analysis that resulted in the 0.2 percent reduction in IPPS payments. They believe that CMS' response was inadequate, and when subject to independent actuarial scrutiny, is shown to be defective.[23] The Providers believe that, as the result of the application of the 2-midnight rule, there will be a substantial shift from inpatient admissions to outpatient encounters, entitling the Providers to an increase in its IPPS rate.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and provided the parties notice of the Board's proposed own motion EJR to which a response was due on October 18, 2015. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 22, 2014 Federal Register[24] and the amount in controversy in each case exceeds the $10,000 threshold necessary for an individual appeal.[25] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR on the Board's own motion is appropriate for the issue under dispute in these cases.

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[23] *See* Providers' October 7, 2014 Hearing Request, Tab 2, n.1.
[24] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[25] *See* 42 C.F.R. § 405.1835(a)(2).

The Board finds that:

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

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

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

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

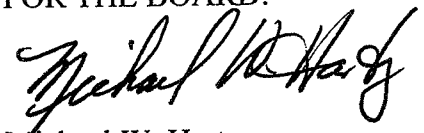
Accordingly, the Board finds on its own motion that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants for expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this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

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services

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

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

Refer to: 16-0053

CERTIFIED MAIL

JUL 08 2016

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

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
P.O. Box 14172
Madison, WI 53708-0172

RE: Oaklawn Hospital
Provider No.: 23-0217
FYE: 06/30/2013
PRRB Case No.: 16-0053

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background

Oaklawn Hospital (the Provider) was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2013 on March 31, 2015. On October 6, 2015, the Board received the Provider's individual appeal request appealing the issue of Outlier Payments – Fixed Costs Threshold. On June 13, 2016, the Board received the Provider's Request to transfer the Outlier Payments – Fixed Costs Threshold issue to PRRB Case Number 16-1831G.

Board's Decision

The Board finds that it does not have jurisdiction over this individual appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states that:

> Unless the provider qualifies for a good cause extension…the date of the receipt by the Board of the provider's hearing request is…No later than 180 days after the date of receipt by the provider of the intermediary or Secretary Determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery

when document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, the Provider's NPR was issued on March 31, 2015. For an appeal to have been timely filed, the appeal request must have been received by the Board no later than Friday October 2, 2015. However, the Board did not receive the Provider's Individual Appeal Request until October 6, 2015, four days past the filing deadline. Because the Provider's Individual Appeal Request was not received by the Board within 180 days as required by 42 C.F.R § 405.1835, the Board finds that this appeal was not timely filed and hereby dismisses the appeal.

The Provider also requested to transfer the issue of Outlier Payments – Fixed Loss Threshold to a group appeal, PRRB case number 16-1831G. The Board denies this request because the appeal was not timely filed. Case number 16-0053 is dismissed and removed from the Board's docket.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Esq., CPA, FSS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Baltimore MD 21244-2670

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

Refer to: Certified Mail

JUL 08 2016

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

RE: **Expedited Judicial Review Determination**

PRRB Case	Group Name
16-0847GC	HRS WKHS FFY 2016 2 Midnight CIRP Group
16-0849GC	HRS UHHS FFY 2016 2 Midnight CIRP Group
16-0947GC	HRS ProMedica Health System FFY 2016 Two Midnight CIRP Group
16-0957GC	HRS Prime Healthcare FFY 2016 2 Midnight Rule CIRP Group
16-0965GC	HRS FMOLHS FFY 2016 Two Midnight CIRP Group
16-0969GC	HRS Lafayette General Health FFY 2016 Two Midnight CIRP Group
16-0983GC	HRS ECHN FFY 2016 Two Midnight CIRP Group
16-0985GC	HRS SCHS FFY 2016 Two Midnight CIRP Group
16-0988G	HRS FFY 2016 Two Midnight Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 13, 2016 request for expedited judicial review ("EJR") (received June 15, 2016). The Board's decision regarding EJR is set forth below.

Issue Under Appeal

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

[1] Providers' May 15, 2015 EJR Requests at 3.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year ("CY") Outpatient PPS ("OPPS") rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

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

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expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges ("ALJs"). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that 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

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date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on 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

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

net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[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 Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital at least over a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,593 (Aug. 17, 2016).

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[20]

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B instead.[21]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[22]

With respect to assumptions 3 and 4, it may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission, that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[23]

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[20] Providers' EJR requests at 8.
[21] *Id.* at 9.
[22] *Id.*
[23] *Id. at 9-10.*

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result in the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[24] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' requests for EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction[25] to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 17, 2015 Federal Register[26] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[27] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these group appeals.

The Board finds that:

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

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

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[24] *Id. at 11.*

[25] The Board notes that one or more of the participants in this consolidated group appeal decision have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

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

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

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

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

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

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

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS Administrators
Evaline Alcantara, Noridian Healthcare Solutions
Byron Lamprecht, Wisconsin Physician Services
Pam Van Arsdale, NGS
Wilson C. Leong, Federal Specialized Services

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CERTIFIED MAIL

JUL 11 2016

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RE: Jurisdictional Challenge Request for Bifurcation
Essentia Health System 2006 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-1672GC

Dear Mr. Knight and Ms. Hartley:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the St. Joseph Health System 2005 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days CIRP Group April 19, 2016 request to bifurcate the providers' dual eligible Part A non-covered and HMO/Part C[1] days issues.

Background

The Board received the request to form a group appeal on May 12, 2009. On May 31, 2015, the Medicare Contractor submitted a jurisdictional challenge to the Board, to which the group representative, Toyon Associates, Inc. ("Toyon"), responded on August 27, 2015. Finally, the Board received Toyon's request for issue bifurcation on April 20, 2016.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor argues that the Board should find that it does not have jurisdiction over Participant 1, SMDC Medical Center (provider number 24-0019, FYE 6/30/2006) because it did not timely add the dual eligible days issue to its individual appeal request prior to transferring the issue to this group. Furthermore, the Medicare Contractor also notes that the Board should find that it does not have jurisdiction over the Low Income Payments ("LIP") issue raised by the same Provider as that issue is governed by separate regulations and should not be included in this appeal.

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. As Charity has used the terms HMO days and Part C Days interchangeably for both time periods, the Board will simplify things by referring to the days collectively as "Part C days."

Last, the Medicare Contractor notes that the Providers did not include the proper transfer documents for Participant 2, St. Mary's Medical Center (provide3r number 24-0002, FYE 6/30/2016). The Provider included a letter transferring the dual eligible days issue for FYE 6/30/2005 to case number 09-1670GC with the schedule of providers and jurisdictional documentation.

Providers' Response to Jurisdictional Challenge

Toyon argues that the Board has jurisdiction over Participant 1 because the Medicare Contractor made an adjustment to Medicaid DSH payments and to Medicaid eligible days. Toyon argues that because the Provider filed its individual appeal request with the Board prior to the regulation and rule changes effective August 21, 2008, that it was a "common and accepted" practice for Providers to address multiple components of an issue as a single issue within an appeal request as long as the appropriate audit adjustment numbers are identified. Toyon then goes on to argue that the Medicaid eligible days issue contains multiple sub-issues, including dual eligible Part A and dual eligible Part C days.

Toyon also argues that the Medicare Contractor did not follow the provisions of CMS Ruling 97-2 or CMS Program Memorandum A-99-62.

Board's Decision

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (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 ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt by the provider of the final determination.

The Board finds that it does not have jurisdiction over Participant 1, SMDC Medical Center (provider number 24-0019, 6/30/2006), because the Provider did not appeal or timely add the dual eligible days issue to its individual appeal. The Provider filed its appeal request with the Board on February 29, 2008, and did not include the dual eligible days issue in its appeal request. The Provider does not raise the issue until its June 5, 2009 request to transfer the issue from its individual appeal to this group appeal. The Provider argues that the dual eligible days issue can be read as a sub-issue of the Medicaid eligible days issue, however these are in fact two distinct issues. It would be too broad to read the Medicaid eligible days issue as including the dual eligible Part A non-covered and Part C days issues as sub-issues.[2]

Effective August 21, 2008, new regulations and Board rules were implemented that require more specificity in issue statements and that also limit the time that a Provider can add an issue to its

[2] *See Stormont-Vail Regional Medical Center v. Sebelius*, 708 F. Supp. 2d 1178, 1186 (D. Kan. 2010), *aff'd* 435 F. App'x.738 (10th Cir. 2011) (finding that, "It is inconsistent with these instructions to construe the 'Medicaid eligible' days issue raised in the original appeal so broadly as to include the 'general assistance' days issue plaintiff sought to add to the appeal.")

individual appeal. Under these rules and regulations, the Provider had until October 21, 2008 to add issues to its pending individual appeal. The Provider did not raise the issue until its 2009 transfer request. Therefore, the Board finds that it does not have jurisdiction over Participant 1 and hereby dismisses the Provider from this appeal.

The Board also finds that it does not have jurisdiction over the LIP dual eligible days issue as it was not timely appealed or added to its individual appeal.

Finally, the Board finds that Participant 2 did properly transfer the dual eligible days issue into this group appeal. Although the letter included with the Schedule of Providers references a different group appeal number, Participant 2 was transferred to this group as part of the group appeal request, as documented in the case file.

Bifurcation

The Board hereby denies the Providers' request for bifurcation of the dual eligible Part A and Part C days issues. The Providers were already participants in a Part C days group that was established for this chain, case number 10-0144GC, Essentia 2006 DSH Dual Eligible Part C Days CIRP Group. Case number 10-0144GC was dismissed on 5/8/2015 for failure to respond to a status request letter. As enumerated in PRRB Rule 4.7 and upheld by the court in *Golden Baptist-Triangle Memorial Hospital v. Leavitt*,[3] once an issue is dismissed, the issue may not be appealed in another case. Therefore, the Board denies the Providers' request for bifurcation of the dual eligible Part A and Part C days issues.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

cc: Wilson Leong, Federal Specialized Services

[3] 566 F.3d 226 (D.C. Cir. 2009).

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Refer to: 16-1092G
Certified Mail

JUL 11 2016

Russell Kramer
Director
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue
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RE: QRS FFY 2016 Two Midnight Census IPPS Payment Reduction Group
Provider Nos. Various
FFY 2016
PRRB Case No. 16-1092G

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 16, 2016 request for expedited judicial review ("EJR") (received 17, 2016). The Board's decision regarding EJR is set forth below.

Issue Under Appeal

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

Statutory and Regulatory Background

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

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[1] Providers' May 16, 2015 EJR Requests 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).

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

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).
[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 the $220 million in additional IPPS expenditures associated with the 2-midnight policy.

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

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 Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital at least over a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[20]

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,593 (Aug. 17, 2016).
[20] Providers' EJR requests at 8.

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B instead.[21]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[22]

With respect to assumptions 3 and 4, it may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission, that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[23]

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result in the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[24] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

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[21] *Id.* at 9.
[22] *Id.*
[23] *Id. at 9-10.*
[24] *Id. at 11.*

Decision of the Board

Jurisdiction

Withdrawn Providers

The Board notes that the following Providers were withdrawn from the appeal through correspondence dated March 16, 2015. The Providers listed below will be deleted from the Schedule of Providers:

13 Thorek Memorial Hospital, provider number 14-0115
14 Kentuckliana Medical Center, provider number 15-0176
18 Abbeville General Hospital, provider number 19-0034
25 Heart of Lafayette, provider number 19-0263

Letters of Representation

The letters of representation from Joseph F. Lapid of Nathan Consulting Group authorized Quality Reimbursement Services' representation for:

2 Dameron Hospital, provider no. 05-0122
3 Community Memorial Hospital of San Buenaventura, provider number 05-0394

Board Rule 5.4[25] requires the following to designate a representative:

> The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. The letter must reflect the Provider's fiscal year under appeal and must contain the following contact information: name, organization, address, telephone number, fax number and e-mail address of the representative.

Since the Group Representative failed to submit a letter designating representation from the authorized representative of each facility, as required, the Board hereby dismisses Dameron Hospital and Community Memorial Hospital of San Buenaventura from the appeal.

EJR Determination

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

[25] *See also* Board Rule 12.4 which mirrors the language for letters of representation and applies to group appeals. The Board's Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

question relevant to the matter at issue once it has made a finding that it has jurisdiction[26] to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers that remain on the Schedule of Providers timely filed their requests for hearing from the issuance of the August 17, 2015 Federal Register[27] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[28] Consequently, the Board has determined that it has jurisdiction over Providers' appeal. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute for the Providers remaining on the Schedule of Providers in this appeal.

The Board finds that:

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

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

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

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

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

---

[26] The Board notes that one or more of the participants in this group appeal decision have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

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

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

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

Board Members Participating

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FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Byron Lamprecht, Wisconsin Physician Services (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

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JUL 11 2016

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

RE: **Expedited Judicial Review Determination**

PRRB Case	Group Name
16-0921GC	QRS Multicare Health 2016 Two Midnight Census IPPS Payment Reduction Group
16-0945GC	QRS Broward Health FFY 2016 Two Midnight Census IPPS Payment Reduction Group
16-0962GC	QRS HonorHealth 2016 Two Midnight Census IPPS Payment Reduction Group
16-0970GC	QRS Novant Health 2016 Two Midnight Census IPPS Payment Reduction Group
16-0973GC	QRS Avera Health 2016 Two Midnight Census IPPS Payment Reduction Group
16-0974GC	QRS BSWH 2016 Two Midnight Census IPPS Payment Reduction Group
16-1020GC	QRS SGHS 2016 Two Midnight Census IPPS Payment Reduction Group
16-1023GC	QRS Ardent Health 2016 Two Midnight Census IPPS Payment Reduction Group
16-1085GC	QRS Healthfirst FFY 2016 Two Midnight Census IPPS Payment Reduction Group
16-1086GC	QRS Asante Health FFY 2016 Two Midnight Census IPPS Payment Reduction Group
16-1087GC	QRS WCHN FFY 2016 Two Midnight Census IPPS Payment Reduction Group
16-1093GC	QRS WFHC FFY 2016 Two Midnight Census IPPS Payment Reduction Group

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 15 and 16, 2016 requests for expedited judicial review ("EJR") (received June 16 and 17, 2016). The Board's decision regarding EJR is set forth below.

Issue Under Appeal

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year ("CY") Outpatient PPS ("OPPS") rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

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]

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[1] Providers' May 15 and 16, 2015 EJR Requests 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).
[4] *Id.*
[5] *Id.*

Medicare Part A

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

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges ("ALJs"). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that 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

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

contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on 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

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[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013).
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*

physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] 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 Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital at least over a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

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[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,593 (Aug. 17, 2016).

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[20]

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B instead.[21]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[22]

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[20] Providers' EJR requests at 8.
[21] *Id.* at 9.
[22] *Id.*

With respect to assumptions 3 and 4, it may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission, that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[23]

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result in the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[24] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' requests for EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction[25] to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 17, 2015 Federal Register[26] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[27] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the application of the 0.2 percent reduction, for which the background regarding its promulgation is found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the

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[23] *Id. at 9-10.*
[24] *Id. at 11.*
[25] The Board notes that one or more of the participants in this consolidated group appeal decision have cost report periods beginning on or after January 1, 2016, which would subject their appeals to the newly-added 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.
[26] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is not a report which is necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Grp. Appeal* (HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[27] *See* 42 C.F.R. § 405.1837(a)(3).

authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in these group appeals.

The Board finds that:

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

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

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

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

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

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

Board Members Participating

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Clayton J. Nix, Esq.
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FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Byron Lamprecht, Wisconsin Physician Services (Certified Mail w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (Certified Mail w/Schedules of Providers)
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RE: Stanford Hospital and Clinics
Provider No.: 05-0441
FYE: 8/31/01
PRRB Case No.: 08-1750

Dear Mr. Knight and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on April 8, 2008, based on a Notice of Program Reimbursement ("NPR") dated October 12, 2007. The hearing request included fourteen issues. The Provider subsequently added twelve additional issues, bringing the total number of issues to twenty-six. Eight issues were subsequently transferred to group appeals and seven issues were subsequently withdrawn. Nine issues were fully resolved in a partial administrative resolution dated October 13, 2014. In addition, two issues were partially resolved: Issue No. 8 – Graduate Medical Education (GME) Interns and Residents Full-Time Equivalent (FTE) Counts and Issue No. 9 – Indirect Medical Education (IME) Interns and Residents FTE Counts and Prior Year Resident-to-Bed Ratio. The portion of these two issues pertaining to Current Year FTE Counts remain in the appeal.

The Medicare Contractor submitted a jurisdictional challenge on the Current Year GME and IME FTE Counts issues on June 9, 2014.[1] The Provider submitted a responsive brief on June 27, 2014.

Medicare Contractor's Position

The Medicare Contractor cites to the statute at 42 U.S.C. § 1395oo(a)(1)(A)(i) and the regulation at 42 C.F.R. § 405.1835(a)(1) concerning dissatisfaction. The Medicare Contractor contends that the Provider is requesting to add FTEs in the current year count that were not submitted on the as-filed cost report. The Medicare Contractor argues that the Provider is not able to demonstrate that it meets the

[1] The Medicare Contractor's jurisdictional challenge also stated that the challenged Current Year GME and IME FTE Counts were also present in Issue 19 – Interns and Resident FTE Counts Related to Approved Programs. The Partial Administrative Resolution indicates that these FTEs are included in Issue Nos. 8 and 9, and in the Provider's final position paper the FTEs under appeal for Issue 19 are combined and addressed under Issues 8 and 9.

dissatisfaction requirement for the contested GME and IME FTEs at issue. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the specific GME or IME FTEs in question. The Medicare Contractor did not adjust to disallow these FTEs in the October 12, 2007 final determination. There is no adverse finding from which the Provider can claim dissatisfaction.[2]

The Medicare Contractor contends that the Provider had many options to properly claim reimbursement related to the contested GME and IME FTEs. The Provider could have claimed reimbursement for these GME and IME FTEs directly on its as-filed cost report, or as a clearly identified protested amount. The Provider could have requested to file an amended cost report before the audit was performed. The Provider could have requested a reopening after the issuance of the NPR. The Provider did not avail itself of any of these opportunities. Additionally, although the Provider did file clearly identified protested amounts related to several other reimbursement issues, there was nothing included in the protested amount related to GME or IME FTEs.[3]

The Medicare Contactor cited the Board's jurisdictional decision in PRRB Case No. 07-0916 St. Luke's Hospital issued February 5, 2014 in support of its position. The Medicare Contractor notes that in that case, the Provider inadvertently omitted the GME and IME FTEs in its cost report. The Board dismissed this issue from the appeal, as the Provider was not precluded by statute, regulation, or a manual provision from filing the FTEs on the cost report.[4]

Provider's Position

The Provider notes the Medicare Contractor's position is that the Provider does not have a right to a hearing on the contested FTEs since the Medicare Contractor did not make an adjustment to disallow these FTEs and the Provider did not preserve its right to claim dissatisfaction since it did not file a claim for the contested FTEs. The Provider states that the Medicare Contractor's position was based on Medicare regulations in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-08 Edition and Medicare Cost Reporting Instructions in CMS 15-2, § 115. The Provider contends that the Medicare Contractor's position is based on Medicare regulations that were not in effect during the Provider's cost reporting period. The Medicare Contractor should have used the Medicare regulations as set forth in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-07 Edition. Under the 2007 regulations, the only criterion for a Provider's right to a hearing is that a Medicare Contractor determination has been made with respect to the Provider. The Provider contends that it met this criterion as the NPR issued on October 12, 2007 clearly states the Medicare Contractor has made a determination with respect to the Provider's cost report as defined in 42 C.F.R. § 405.1801(a)(2).[5]

The Provider argues that the Medicare Contractor posted adjustments to the Provider's reported IME/GME current year FTE counts in the final NPR. The Provider's dissatisfaction stems from the Medicare Contractor's issuance of the final NPR. The Provider's dissatisfaction is derived from the fact that if the Provider was allowed to include the additional IME/GME current year FTEs in its Medicare

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[2] Medicare Contractor's jurisdictional challenge at 4-5.
[3] *Id.* at 5.
[4] *Id.* at 6.
[5] Provider's jurisdictional response at 5-7.

cost report, the Provider's IME and GME entitlement would increase substantially over what is currently present in the final NPR today.[6]

The Provider argues that the jurisdictional decision cited by the Medicare Contractor to support its position is not applicable to this case. In the instant case, the Provider actually claimed reimbursement for IME/GME in its as-filed cost report and the Medicare Contractor made adjustments to the as-filed FTEs.[7]

Board's Decision

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

The Board concludes that it does not have jurisdiction over the additional Intern and Resident FTEs for IME and GME issues in this appeal because the Provider received reimbursement for the items and services as claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of the dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> > (1) such provider
> >
> > (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a), the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of

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[6] *Id.* at 7-8.
7 *Id.* at 8.

> services) even though such matters were not considered by the intermediary in making such final determination.

The Provider received reimbursement based on the way it claimed IME and GME FTE's on its as-filed cost report. Any reporting errors were due solely to the Provider's negligence. Only in hindsight did the Provider determine that it should have claimed these items differently, thereby increasing the amount of reimbursement.

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

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[8]

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

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[9]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[10] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[11] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which

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[8] *Bethesda.* at 1258, 1259. (Emphasis added).
[9] *Id.* at 1259. (Emphasis added).
[10] Emphasis added.
[11] 24 F.3d 984 (7th Cir. 1994).

establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[12]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[13] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[14] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[15]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[16] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[17]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[18] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[19] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal.

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[12] *Little Co. I,* 24 F.3d at 992.
[13] *Little Co. of Mary Hosp. v. Shalala*, 165 F.3d 1162 (7th Cir. 1999).
[14] *Little Co. II*, 165 F.3d at 1165.
[15] *Id.*
[16] 73 Fed. Reg. at 30196.
[17] 73 Fed. Reg. at 30203.
[18] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[19] 492 F.3d 1065 (9th Cir. 2007).

The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[20]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[21] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[22] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[23] which were decisions issued in 2000 and 1987 respectively.[24]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[25] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[26]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[27] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power

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[20] *Id.* at 1068 (emphasis added).
[21] *See* 73 Fed. Reg. at 30197.
[22] 205 F.3d 493 (1st Cir. 2000).
[23] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[24] *See Loma Linda,* 492 F.3d at 1068.
[25] *St. Luke's*, 810 F.2d at 332.
[26] *Id.* at 327-328 (emphasis in original).
[27] *MaineGeneral*, 205 F.3d at 501.

to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[28] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word "'dissatisfied'" is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[29]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.,* unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[30] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[31]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[32]

Finally, and most recently, the D.C. District Court found in favor of the agency's interpretation of the dissatisfaction requirement in 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius.* [33] Similarly, in that appeal, the PRRB determined that plaintiff "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations

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[28] *St. Luke's,* 810 F.2d at 327.
[29] *MaineGeneral,* 205 F.3d at 501.
[30] *UMDNJ Univ. Hosp. v. Leavitt,* 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[31] *Id.* at 79.
[32] *Id.* at 77.
[33] *Saint Vincent Indianapolis Hospital v. Sebelius,* 2015 WL 5728372 (D.D.C 2015).

governing the reimbursement of such costs" rather than the FI/MAC's action. The Court found that in reviewing both parties analysis of the statutory language and the relevant case law, that the Board's jurisdictional determination was applying the language of the Medicare Act and therefore the Court grants the agency's interpretation deference. Additionally, the Court found that the PRRB's ruling was based upon "a permissible construction of the statute", and therefore upheld the PRRB's dismissal.

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[34] However, the Provider is located in the Seventh Circuit and, as such, *Little Co. I* and *Little Co. II* apply to this appeal and serve as controlling precedent for the Board.[35]

In the instant case, it is undisputed that the Provider did not include the additional intern and resident FTEs for IME and GME in its as-filed cost report. Only in hindsight did the Provider determine that it could have reported the current year IME and GME FTE counts differently, thereby increasing the

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[34] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[35] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alhambra* [*Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision . . . with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit . . . . The decision does not affect the Secretary's ability to continue to defend this issue in other circuits . . . ."); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)). Further, the Board notes that, while the Provider could appeal the Board's decision in the D.C. District Court, the D.C. Circuit has not yet reviewed and ruled on this issue. *See Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating with respect to a provider located in Massachusetts that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here"). Accordingly, the Board applies the law of the Seventh Circuit as controlling precedent.

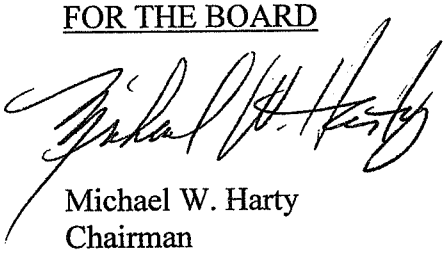
amount of reimbursement. This case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[36] The Board notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[37]

Therefore, the Board dismisses the additional Intern and Resident FTEs for IME and GME issues from the appeal. The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) or § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.

As there are no issues remaining in the appeal, the Board hereby closes this case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
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
1701 S. Racine Avenue
Chicago, IL 60608-4058

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[36] *Bethesda*, 485 U.S. at 404-405.
[37] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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CERTIFIED MAIL

JUL 12 2016

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

RE: San Francisco General Hospital
Provider No.: 05-0228
FYE: 6/30/03
PRRB Case No.: 10-1152

Dear Ms. Oliva and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on July 14, 2010, based on a Notice of Program Reimbursement ("NPR") dated January 22, 2010. The hearing request included nineteen issues, seven of which were subsequently transferred to group appeals and one of which was subsequently withdrawn. Nine issues were fully resolved in a partial administrative resolution dated October 9, 2014. The following issues were partially resolved in the same partial administrative resolution:

- Issue No. 15 – Indirect Medical Education (IME) Payments – IME FTE Count
- Issue No. 16 – Graduate Medical Education (GME) Payments – GME FTE Count

The Medicare Contractor submitted a jurisdictional challenge on August 6, 2014 on the one remaining component of these issues – Additional FTEs Not Claimed in the As-Filed Cost Report. The Provider submitted a responsive brief on August 27, 2014.

Medicare Contractor's Position

The Medicare Contractor cites to the statute at 42 U.S.C. § 1395oo(a)(1)(A)(i) and the regulation at 42 C.F.R. § 405.1835(a)(1) concerning dissatisfaction. The Medicare Contractor argues that the Provider cannot demonstrate dissatisfaction as the Contractor did not make a final determination. In this case, the Contractor did not make an adjustment to IME and GME for the additional FTEs that were not counted during audit. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the specific FTEs now in question. There was no audit adjustment, so the Provider is dissatisfied

with its own reporting of the intern and resident FTEs for IME and GME, not the Medicare Contractor's determination.[1]

The Medicare Contractor contends that its position is supported by the Administrator's decision in *Norwalk v. BCBS Association/National Government Services, Inc.* issued May 23, 2012 reversing the Board's decision in PRRB Dec. No. 2012-D14. The Contractor argues that in the *Norwalk* decision the Administrator found that the Board did not have jurisdiction over a provider's request for a hearing regarding the issue of Medicaid-eligible days, because the provider was not able to demonstrate that it met the dissatisfaction requirement necessary for Board jurisdiction. In the *Norwalk* decision, the Administrator stated "Moreover, even assuming *arguendo* that there could be a practical impediment to claiming all the costs for which one is entitled to receive payment that could rise to the level of a *Bethesda*-type self-disallowance, the facts in this case do not demonstrate such practical impediment existed here." The Medicare Contractor argues that in the instant case, the Provider has not demonstrated a genuine practical impediment existed in its situation, precluding it from claiming the GME and IME FTEs in question. The Provider has not shown it meets the dissatisfaction requirement.[2]

The Medicare Contractor explains that the Provider had many options to properly claim reimbursement related to the contested GME and IME FTEs. The Provider could have claimed reimbursement for these GME and IME FTEs directly on its as-filed cost report, or as a clearly identified protested amount. The Provider could have availed itself of the right to file an amended cost report before the audit was performed. The Provider could have requested a reopening after the issuance of the NPR. The Provider did not avail itself of any of these opportunities.[3]

Lastly, the Medicare Contractor references three Board jurisdictional decisions in support of its position wherein the Board determined that it did not have jurisdiction.[4] The Contractor asserts that the facts in these cases are similar to the case at issue here. The providers failed to claim the contested items on their as-filed cost reports.

Provider's Position

The Provider notes the [Medicare Contractor's] position that the Provider does not have a right to a hearing on the contested FTEs since the [Medicare Contractor] did not make an adjustment to disallow these FTEs and the Provider did not preserve its right to claim dissatisfaction since it did not file a claim for the contested FTEs. The Provider states that the [Medicare Contractor's] position was based on Medicare regulations in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-08 Edition and Medicare Cost Reporting Instructions in CMS 15-2, § 115. The Provider contends that the [Medicare Contractor's] position is based on Medicare regulations that were not in effect during the Provider's cost reporting period. The [Medicare Contractor] should have used the Medicare regulations as set forth in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-07 Edition. Under the latter regulations, the only criterion for a Provider's right to a hearing is that a [Medicare Contractor] determination has been made with respect to the Provider. The Provider contends that it met this criterion as the NPR issued on January 22, 2010

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[1] Medicare Contractor's jurisdictional challenge at 2-3.
[2] *Id.* at 3.
[3] *Id.*
[4] PRRB Case No. 07-2152 Stanford Hospital and Clinics; PRRB Case No. 07-0916 – St. Luke's Hospital; and PRRB Case No. 08-1657 Martin Luther King, Jr./Drew Medical Center.

clearly states the [Medicare Contractor] has made a determination with respect to the Provider's cost report as defined in 42 C.F.R. § 405.1801(a)(2).[5]

The Provider argues that the [Medicare Contractor] posted adjustments to the Provider's reported IME/GME current year FTE counts in the final NPR. The Provider's dissatisfaction stems from the [Medicare Contractor's] issuance of the final NPR. The Provider's dissatisfaction is derived from the fact that if the Provider was allowed to include the additional IME/GME current year FTEs in its Medicare cost report, the Provider's IME and GME entitlement would increase substantially over what is currently present in the final NPR today.[6]

The Provider contends that its appeal rights on this issue are protected by the Supreme Court's decision in Bethesda Hospital Association et al v. Bowen. The Provider argues that the Supreme Court's decision in *Bethesda* clearly states the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.[7]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (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.

The Board concludes that it does not have jurisdiction over the additional Intern and Resident FTEs for IME and GME issues in this appeal because the Provider received reimbursement for the items and services as claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of the dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services

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[5] Provider's responsive brief at 5.
[6] *Id.* at 8-9.
[7] *Id.* at 9.

> furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a), the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Provider received reimbursement based on the way it claimed IME and GME FTE's on its as-filed cost report. Any reporting errors were due solely to the Provider's negligence. Only in hindsight did the Provider determine that it should have claimed these items differently, thereby increasing the amount of reimbursement.

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

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[8]

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

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[9]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[10] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other

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[8] *Bethesda.* at 1258, 1259. (Emphasis added).
[9] *Id.* at 1259. (Emphasis added).
[10] Emphasis added.

appellate courts have done so. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[11] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[12]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[13] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[14] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[15]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[16] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[17]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[18] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

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[11] 24 F.3d 984 (7th Cir. 1994).
[12] *Little Co. I,* 24 F.3d at 992.
[13] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[14] *Little Co. II,* 165 F.3d at 1165.
[15] *Id.*
[16] 73 Fed. Reg. at 30196.
[17] 73 Fed. Reg. at 30203.
[18] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[19] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal.
The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[20]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[21] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[22] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[23] which were decisions issued in 2000 and 1987 respectively.[24]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[25] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that

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[19] 492 F.3d 1065 (9th Cir. 2007).
[20] *Id.* at 1068 (emphasis added).
[21] *See* 73 Fed. Reg. at 30197.
[22] 205 F.3d 493 (1st Cir. 2000).
[23] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[24] *See Loma Linda,* 492 F.3d at 1068.
[25] *St. Luke's*, 810 F.2d at 332.

the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[26]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[27] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[28] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[29]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[30] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[31]

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[26] *Id.* at 327-328 (emphasis in original).
[27] *MaineGeneral*, 205 F.3d at 501.
[28] *St. Luke's*, 810 F.2d at 327.
[29] *MaineGeneral*, 205 F.3d at 501.
[30] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[31] *Id.* at 79.

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[32]

Finally, and most recently, the D.C. District Court found in favor of the agency's interpretation of the dissatisfaction requirement in 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius.* [33] Similarly, in that appeal, the PRRB determined that plaintiff "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs" rather than the FI/MAC's action. The Court found that in reviewing both parties analysis of the statutory language and the relevant case law, that the Board's jurisdictional determination was applying the language of the Medicare Act and therefore the Court grants the agency's interpretation deference. Additionally, the Court found that the PRRB's ruling was based upon "a permissible construction of the statute", and therefore upheld the PRRB's dismissal.

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[34] However, the Provider is located in the Seventh Circuit and, as such, *Little Co. I* and *Little Co. II* apply to this appeal and serve as controlling precedent for the Board.[35]

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[32] *Id.* at 77.

[33] *Saint Vincent Indianapolis Hospital v. Sebelius,* 2015 WL 5728372 (D.D.C 2015).

[34] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[35] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alhambra* [*Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision . . . with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit . . . . The decision does not affect the Secretary's ability to continue to defend this issue in other circuits . . . ."); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008)

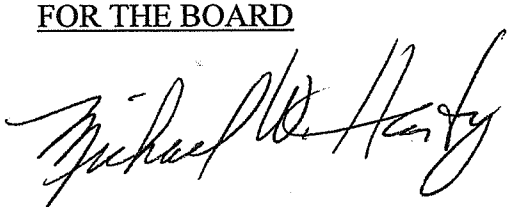
In the instant case, it is undisputed that the Provider did not include the additional intern and resident FTEs for IME and GME in its as-filed cost report. Only in hindsight did the Provider determine that it could have reported the current year IME and GME FTE counts differently, thereby increasing the amount of reimbursement. This case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[36] The Board notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[37]

Therefore, the Board dismisses the additional intern and resident FTEs component of Issue No. 15 – Indirect Medical Education (IME) Payments – IME FTE Count and Issue No. 16 – Graduate Medical Education (GME) Payments – GME FTE Count from the appeal. The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) or § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.

As there are no issues remaining in the appeal, the Board hereby closes this case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, 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
1701 S. Racine Avenue
Chicago, IL 60608-4058

(stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)). Further, the Board notes that, while the Provider could appeal the Board's decision in the D.C. District Court, the D.C. Circuit has not yet reviewed and ruled on this issue. *See Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating with respect to a provider located in Massachusetts that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here"). Accordingly, the Board applies the law of the Seventh Circuit as controlling precedent.

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

[37] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.

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Refer to: 11-0068GC

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JUL 13 2016

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

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

RE: QRS BJC 2004 DSH Medicare Managed Care Part C Days CIRP Group
Jurisdictional Challenge
PN: Various
FYE: 2004 & 2005
PRRB Case Number: 11-0068GC

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge concerning specific providers in this group appeal.

Pertinent Facts:

Parkland Health Center, provider number 26-0163, FYE 12/31/2004

August 11, 2006	The Provider is issued a NPR for FYE 12/31/2004.
February 9, 2007	The Provider filed an individual appeal request from the 8/11/2006 NPR. The Provider appealed two issues: Medicaid eligible days and Bad debts. The Board assigned Case No. 07-0798 to this appeal.
February 1, 2011	The Provider requested to transfer the Medicare Managed Care Part C days issue from Case No. 07-0798 to this group appeal.

Christian Hospital Northeast, provider number 26-0180, FYE 12/31/2005

March 15, 2011	The Provider requested to be directly added to the subject group appeal from a revised NPR issued on September 15, 2010.[1]

[1] *See* Medicare Contractor jurisdictional review dated October 30, 20015 (Schedule of Providers).

Board Analysis and Decision:

Parkland Health Center ("Parkland"), Provider Number 26-0163, FYE 12/31/2004

The Board finds that it does not have jurisdiction over Parkland because the Provider did not properly add the Medicare Managed Care Part C days issue to its individual appeal, Case No. 07-0798. The issue was not included in its initial appeal request. The Provider appealed Medicaid Eligible Days. The issue was stated as:

> "Medicaid Percentage (Eligible Days) ... Specifically, the provider disagrees with the calculation of the second computation of the disproportionate share patient percentage, ... The Intermediary, contrary to the regulation, failed to include as Medicaid-Eligible days service to patients for Medicaid, as well as patients eligible for general assistance."

The first time the Medicare Managed Care Part C days issue was raised was in the Provider's February 1, 2011 transfer request. In that request, the Provider stated that its broad Medicaid eligible issue statement from its appeal request really includes three sub-issues: exhausted benefits dual eligible days, Medicare managed care Part C days, and Medicaid eligible labor and delivery days. The Provider then requested to transfer these three issues to various group appeals.

The February 1, 2011 transfer request letter is essentially a request to add the three issues to the individual appeal. However, this request was not timely pursuant to regulations that went into effect on August 21, 2008, that limited the addition of issues to appeals. 42 C.F.R. § 1835 provides in relevant part:

> (c) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 FR 30,236 (May 23, 2008). This Provider's request did not come until 2011, therefore the Board finds that it does not have jurisdiction over Parkland.

Christian Hospital Northwest ("Christian"), Provider Number 26-0180, FYE 12/31/2005

The Board finds that it does not have jurisdiction over Christian in the appeal because the

Provider appealed from a revised NPR that did not specifically adjust Medicare Managed Care Part C days. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

Christian's audit adjustment report shows an adjustment to Medicaid eligible days and DSH generally, however the Provider did not provide any documentation to establish that Medicare Managed Care Part C days were specifically adjusted as part of any adjustments made.

Summary

Parkland did not properly add the Medicare Managed Care Part C days issue to its individual appeal prior to requesting a transfer, therefore the Board finds that it does not have jurisdiction. The Board denies jurisdiction over Christian because the Provider appealed from a revised NPR that did not specifically adjust Medicare Managed Care Part C days. The Board, hereby, denies jurisdiction over the only Providers included in the subject case and closes Case No. 11-0068GC.

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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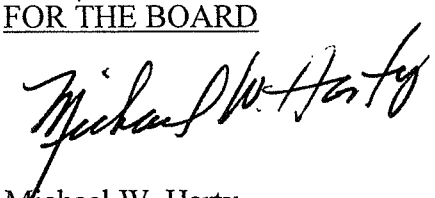
FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Wilson C. Leong, Federal Specialized Services

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Refer to: 16-0221

JUL 20 2016

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Baylor Scott & White Health
Vice President, Reimbursement
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Bill Tisdale
Novitas Solutions, Inc.
Director JH, Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Baylor Medical Center at Carrollton
Provider No.: 45-0730
FYE: 09/30/2012
PRRB Case No.: 16-0221

Dear Mr. Galinsky and Mr. Tisdale,

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

Background

On April 24, 2015, Novitas Solutions, Inc. issued Baylor Medical Center at Carrollton (the Provider) an original Notice of Program Reimbursement (NPR) for Fiscal Year End (FYE) 09/30/2012. On October 28, 2015, the Board received the Provider's individual appeal request appealing multiple issues.

Board's Decision

The Board finds that it does not have jurisdiction over this individual appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states that:

> Unless the provider qualifies for a good cause extension...the date of receipt by the Board of the provider's hearing request is...[n]o later than 180 days after the date of receipt by the provider of the intermediary or Secretary Determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery

when document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, Novitas Solutions, Inc. issued the Provider's NPR on April 24, 2015. For an appeal to have been timely filed, the appeal request must have been received by the Board no later than October 26, 2015. However, the Board did not receive the Provider's Individual Appeal Request until October 28, 2015, which was two days past the allowed filing date. Because the Provider's Individual Appeal Request was not received by the Board within 180 days as required by 42 C.F.R § 405.1835, the Board finds that this appeal was not timely filed. Case number 16-0221 is dismissed and removed from the Board's docket.

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

Board Members Participating
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Jack Ahern, MBA
Charlotte F. Benson, CPA
Clayton J. Nix, Esq.

FOR THE BOARD

Charlotte Benson for
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, FSS

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Refer to: 16-0473

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

RE: Trinity Regional Medical Center
Provider No.: 16-0016
FYE: 12/31/2011
PRRB Case No.: 16-0473

Dear Mr. Blecha and Mr. Lamprecht,

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

Background

On May 12, 2015, Wisconsin Physicians Service issued Trinity Regional Medical Center (the Provider) its Final Determination, the Sole Community Hospital Volume Decrease Adjustment Reconsideration Denial, for Fiscal Year End (FYE) 12/31/2011. On December 21, 2015, the Board received the Provider's individual appeal request.

Board's Decision

The Board finds that it does not have jurisdiction over this individual appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states that:

> Unless the provider qualifies for a good cause extension...the date of receipt by the Board of the provider's hearing request is...[n]o later than 180 days after the date of receipt by the provider of the intermediary or Secretary Determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery when document is transmitted by a nationally-recognized next-day courier or, alternatively, the

date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, Wisconsin Physicians Service issued the Provider's Final Determination on May 12, 2015. For an appeal to have been timely filed, the appeal request must have been received by the Board no later than November 13, 2015. However, the Board did not receive the Provider's Individual Appeal Request until December 21, 2015, which was 39 days past the allowed filing date. Because the Provider's Individual Appeal Request was not received by the Board within 180 days as required by 42 C.F.R § 405.1835, the Board finds that this appeal was not timely filed. Case number 16-0473 is dismissed and removed from the Board's docket.

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

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

FOR THE BOARD

Charlotte Benson for

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, FSS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 11-0808

JUL 29 2016

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – Bay Medical Center
Provider No.: 10-0026
FYE: 9/30/2009
PRRB Case No.: 11-0808

Dear Ms. Erde and Mr. Pike,

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

Background

On August 30, 2011, the Provider Reimbursement Review Board ("Board") received a request for hearing for Bay Medical Center, Provider no. 10-0026, fiscal year ("FYE") 09/30/2009. The appeal request was based on the lack of a timely issued notice of program reimbursement ("NPR") and contained one issue, Inpatient and Outpatient Indigent Bad Debt. This appeal request was assigned case number 11-0808.

The Medicare Contractor challenged the Board's jurisdiction over the case on September 04, 2012. On June 24, 2015, the Board requested that the Provider respond to the jurisdictional challenge and provide additional documentation. The Providers responsive brief was received on July 24, 2015.

Medicare Contractor's Contentions

The Medicare Contractor asserts that the Provider filed the appeal request based on draft audit adjustments received from the Medicare Contractor and not on final audit adjustments, and therefore there was no final determination from which to appeal. The Medicare Contractor states that the NPR had not yet been issued per instructions issued by the Centers for Medicare & Medicaid Services ("CMS") to delay issuing a NPR for cost reports that contain Supplemental Security Income ("SSI") data that is used in the Disproportionate Share Adjustment ("DSH"), and therefore the appeal is premature.

Provider's Contentions

Citing 42 U.S.C. §1395 oo(a)(1)(b) and 42 C.F.R. §405.1835(a)(3), the Provider contends that the Board does have jurisdiction over the case as the appeal was filed from a lack of a timely NPR determination. The Board's jurisdiction is not impinged because the Medicare Contractor was required under CMS instruction to delay issuance of the hospital's NPR. Further, the Provider states that the Medicare Contractor's contention that the appeal was based on draft audit adjustments and not final audit

adjustments is misplaced. The Provider states that final audit adjustments are not required for appeals filed from a failure to issue the NPR, but the inclusion of the draft adjustments was reasonable since the Medicare Contractor had completed the audit of the Provider's bad debts.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because it was not timely filed from the non-issuance of the Provider's NPR.

As cited by the Provider, 42 C.F.R. 405.1835(a)(3)(ii) (2010) governs the Board's jurisdiction when the Medicare Contractor fails to issue an NPR, as is the case here. The regulation defines the filing deadline as:

> If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), *no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination.* (Emphasis added).

The Medicare Contractor received the Provider's cost report on February 23, 2010.[1] The Medicare Contractor had twelve months to issue the Provider's NPR, but did not do so. The Provider then had 180 days from February 23, 2011 to file its appeal request with the Board (until August 22, 2011). The Board received the Provider's appeal request 188 days later on August 30, 2011. Therefore, the Board concludes that Bay Medical Center did not timely file its appeal request and the Board does not have jurisdiction. The Board hereby dismisses the individual appeal for case number 11-0808.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Wilson Leong, Federal Specialized Services

[1] Provider jurisdictional response (July 23, 2015), Ex. D at 1.