PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D47

PROVIDER –
Illinois Masonic Medical Center

Provider No.: 14-0132

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

Cost Reporting Period Ended –
June 30, 1997

CASE NO.: 08-2017

INDEX

ISSUE:

Whether the Provider Reimbursement Review Board has jurisdiction over Medicaid eligible days that were not specifically considered within the implementation of a revised Notice of Program Reimbursement (NPR).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The underlying issue in dispute in these cases involves the proper amount of Medicare reimbursement due providers of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (HHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare Administrative Contractors (MAC). FIs and MACs determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. See, 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803.

A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) provided it meets the following conditions: (1) The provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy for a single provider must exceed $10,000 for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-405.1837.

The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. §405.1889. This regulation provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811[right to intermediary hearing], 405.1835 [right to Board hearing], 405.1875 [CMS Administrator's review] and 405.1877 [judicial review] are applicable.

A Medicare Disproportionate Share Hospital (DSH) payment is an adjustment to the inpatient prospective payment system (IPPS) payment rates. See, 42 U.S.C. § 1395ww(d)(5)(F)(vi) and 42 C.F.R. §412.106. The DSH payment is based on whether a hospital meets certain criteria (e.g. number of beds, geographical location) and whether it treats a threshold number of low

income patients. Once the hospital meets the threshold eligibility for a DSH adjustment, the amount of the payment increases with the number of low income patients treated. The adjustment is the sum of two fractions, the Medicare and Medicaid fractions, expressed as a percentage. The Medicare fraction (also known as the SSI fraction) utilizes the number of hospital patient days for Medicare patients who are eligible for Supplemental Security Income (SSI). The Medicaid fraction is derived from the number of hospital patient days for patients entitled to medical assistance under Title XIX of the Social Security Act, which established the Medicaid program.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider appealed Medicaid eligible days for purposes of the DSH calculation and joined a group appeal, Case Number 98-2694G. On October 9, 2007, the Group representative and the Intermediary executed a Full Administrative Resolution for Case Number 98-2694G (A/R). Within this A/R, the agreement related to the Provider was stated as follows:[1]

> The Provider and the Intermediary jointly agree to the following stipulations for the following providers:
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> * * * * *
>
> c) 14-0132, FY June 30, 1997 – No later than October 31, 2007, QRS, the Provider Representative, will provide documentation to support the days claimed are not exempt unit days. If documentation is not provided, the Provider withdraws this appeal with no further action. If documentation is provided, the [Intermediary] will complete the review and issue [its] findings by November 30, 1997. A revised NPR will be issue[d] by December 31, 2007, if appropriate.

The Intermediary issued a revised Notice of Program Reimbursement (NPR) dated December 3, 2007, in which it made an adjustment to add 24 allowable Medicaid eligible days of the 230 days claimed by the Provider. The Provider submitted a timely request for hearing on May 28, 2008, based on this revised NPR, and requested the inclusion of 1,175 additional Medicaid eligible days for purposes of the DSH calculation. The Provider raised the following issue:

> The Provider contends that the Fiscal Intermediary did not determine Medicare reimbursement for disproportionate share hospitals (DSH) in accordance with the statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate share patient percentage, set forth at 42 C.F.R. §412.106(b)(4) of the Secretary's regulations. The intermediary, contrary to the regulation, failed to include as Medicaid-Eligible Days services to patients for Medicaid, as well as patients eligible for general assistance.

On July 28, 2008, the Intermediary challenged the Board's jurisdiction over this DSH issue, and on August 27, 2008, the Provider submitted a responsive letter. On October 27, 2009, the Board

[1] See Intermediary's Jurisdictional Challenge, Exhibit I-1 at 2, and Exhibit I-2 at 2.

requested additional supporting documentation, to which the Provider replied on November 25, 2009.

By the letter dated November 25, 2009, the Provider identified two distinct categories of days. The first category is the original listing of 230 days, which are identified as patients with Medicaid secondary coverage, but for whom no payment was received from either Medicare or Medicaid. The second is the current listing of 2,244 additional unpaid, but Medicaid eligible days in dispute, which is inclusive of the 1,175 days raised in the appeal request and 1,069 supplemental days based on a more detailed review of days in conjunction with data from the State of Illinois. The Provider stated that "[n]one of the days in the current list were included in the original list."

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the Provider was part of a group appeal, Case Number 98-2694G, in which the exact same issue was appealed and resolved through a Full Administrative Resolution (AR). Through the AR and subsequent timely revised NPR, the Intermediary considered the issue resolved and the case to be final, and contends that it is inappropriate for the Provider to now enlarge the appeal by requesting additional days that were not previously claimed or reviewed.

Specifically, the Intermediary states that it already addressed the issue of Medicaid eligible days in the DSH calculation when the Intermediary reviewed the 230 additional Medicaid eligible days submitted by the Provider for review. The Intermediary concluded that 24 of the 230 Medicaid eligible days were allowable and adjusted the days within the December 3, 2007, revised NPR. The Intermediary did not allow the remaining 206 days due to lack of documentation, lack of Medicaid eligibility, and various other reasons. The Provider did not request the review or transfer of general assistance days, and the Intermediary made no adjustment for such days.

PROVIDER'S CONTENTIONS:

The Provider contends that it has the right to appeal the issue addressed in the revised NPR per the provisions of 42 C.F.R. §405.1889 [effect of a revision] and 42 C.F.R. §405.1835 [right to Board hearing].

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority finds that it lacks jurisdiction under 42 U.S.C. 1395oo(a) over the additional Medicaid eligible day issue because the Provider fails to meet the requirement that it be "dissatisfied" with the Intermediary's final determination in the revised NPR. The Provider claimed 230 days under the terms of the AR for Case Number 98-2694G. The Intermediary reviewed these days and determined that the Provider had fully documented 24 of the 230 days. The Intermediary revised the cost report to include 24 Medicaid eligible days and effectively disallowed the remaining 206 days.[2] However, the Provider did not appeal the 206 days disallowed from this universe. The Provider appealed 2,244 days and concedes that there is no overlap between the original listing of 230 days and the new listing of 2,244 days. Therefore, the

[2] See Intermediary's Jurisdictional Challenge at 4, Exhibit I-5 at 3, and Exhibit I-6 at 2.

2,244 days in dispute in the current appeal were not considered by the Intermediary when the cost report was revised since the Provider did not seek the inclusion of these days, nor did the Intermediary review these days.[3]

Once jurisdiction is obtained under 42 U.S.C. §1395oo(a), subsection (d) gives the Board discretionary power to review additional matters not considered by the Intermediary.[4] In this case, however, the only issue involves days omitted by the Provider. There is no mention of dissatisfaction with disallowances of any costs on the revised cost report and, consequently, there is no jurisdictionally valid appeal on which discretionary review could be based. Moreover, even if a jurisdictionally valid appeal had been filed, the Board majority would decline to exercise its discretionary power in these circumstances because it would undermine the principles of finality in the cost reporting process and bypass the intermediary determination process.

DECISION OF THE BOARD:

The Board concludes it lacks jurisdiction over the additional Medicaid eligible day issue, and as this is the only issue in dispute, the Board also dismisses the case. 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

Suzanne Cochran, Esq.
Yvette C. Hayes (dissenting opinion)
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: September 17, 2010

[3] The limit on issues that can be appealed from revised NPRs was discussed in Health Care Corporation of America v. Shalala, 27 F. 3d 614 (D.C.Cir.1994). In that case, the Court concluded that when an intermediary reopens a determination regarding the amount of reimbursement that a Medicare provider is to receive, an appeal of the reopened cost report is limited to the specific issues revised on reopening and may not be extended further to all determinations underlying the original reimbursement determination for the fiscal year in question.

[4] See, MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000); Loma Linda Univ. Med Ctr v. Leavitt, 492 F.3d 1065 (9th Cir. 2007); and UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008), discussing the application of Bethesda Hospital Assoc. v. Bowen, 485 U.S. 399 (1988), to costs inadvertently omitted from the cost report.

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I respectfully dissent with the Board majority's conclusion that it lacks jurisdiction under 42 U.S.C. §1395oo (a) over the DSH - Medicaid eligible days issue because the Provider failed to meet the requirement that it be "dissatisfied" with the Intermediary's final determination with respect to a revised NPR.

The Provider contends that it has a right to appeal the issue addressed in the revised NPR[5] per the provisions of 42 C.F.R. §§405.1835 - 405.1837 and 42 C.F.R. §405.1889 as follows:

Section 405.1837 - Group Appeal - states in pertinent part:

(a) …[A] group of providers may bring an appeal before the Board but only if –

(1) Each provider in the group is identified as one which would, upon filing of a request for a hearing before the Board, but without regard to the $10,000 amount in controversy requirement, be entitled to a hearing under §405.1835.

Section 405.1835 – Right to Board hearing - states in pertinent part:

(a) A provider has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if:
(1) An intermediary determination has been made with respect to the provider; and
(2) The Provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
(3) The amount in controversy is $10,000 or more.

Based on my reading of the regulations, the Provider has met all of the jurisdictional requirements. Therefore, the Board has jurisdiction over the matter in dispute in this case and the Provider has a right to a hearing.

In addition, 42 C.F.R. §405.1889 – Effect of a revision - provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§405.1811[right to intermediary hearing], 405.1835[right to Board hearing], 405.1875[CMS Administrator's review] and 405.1877[judicial review] are applicable.

It is undisputed that the issue or matter *adjusted* for in the revised NPR "[t]o incorporate the administrative resolution [AR] of Group PRRB Case # 98-2694G into the cost report[6]" is the same issue or matter[7] that is being appealed. In dispute is whether the AR and NPR issued fully

[5] The Revised NPR was issued on December 3, 2007 and a Request for Hearing was filed on May 28, 2008. This appeal falls under the rules in effect prior to the 2008 Rule change effective August 21, 2008.
[6] Per Notice of Reopening dated November 21, 2007.
[7] The failure to include as Medicaid-eligible days services to patients eligible for Medicaid, as well as patients eligible for general assistance. (Note: The Provider appears to have abandoned the GA issue because the issue was

resolved the matter in perpetuity and therefore prohibits any further disagreement as to the propriety of the amount of Medicaid eligible days included in the DSH calculation.

To address this question, we look to the expressed language in the AR. It states, in pertinent part:

> The [parties] in the above captioned appeal [PRRB Case No. 98-2694G] are entering into this administrative resolution for the purpose of setting forth the basis for resolving the issues that are pending before the PRRB.
>
> Based on a mutual review of the respective parties' position papers, other available documentation and authorities, and further discussions, the parties agree to resolve the case as follows:
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> * * * * *
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> The Provider and the Intermediary jointly agree to the following stipulations for the following providers:
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> > c) 14-0312[8], FY June 30, 1997 – No later than October 31, 2007, [], the Provider Representative, will provide documentation to support the days claimed are not exempt unit days. If documentation is not provided, the Provider withdraws this appeal with no further action. If documentation is provided, the FI will complete the review and issue their findings by November 30, 1997. A Revised NPR will be issued[d] by December 31, 2007, if appropriate.

Based on my reading of the above statements, the parties to the AR agreed on how to resolve (on what basis) the case [PRRB Case No. 98-2694G] in question. This agreement does not extend to or encompass an appeal from the revised NPR. If a cost report is reopened and a revised NPR issued, new appeal rights attach to the revised NPR pursuant to 42 C.F.R. §405.1889.

Further, there is no dispute that two (2) distinct listings have been provided to the Intermediary for its consideration and in support of the amount of Medicaid eligible days requested. In response to the AR for Case No. 98-2694G, an original list was submitted by the Provider for a claim of 230[9] additional Medicaid eligible days. The Intermediary reviewed this list and determined that only 24 of those days were adequately supported as allowable. In support of the Provider's current claim for 2,244 additional Medicaid eligible days, a second list was submitted that showed 2,151 Unpaid Medicaid eligible days (consisting of 1,684 Adults and Pediatrics days and 467 Newborn or Nursery days) and 93 Paid Medicaid eligible days.

No basis has been provided for the Intermediary's position that once an issue – Medicaid eligible days – is addressed in a given appeal that issue is forever resolved and that its inappropriate for

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not specifically addressed in the AR and the Provider's Representative acknowledged that there would be "no transfer of GA/Charity Care Days issue.") See Exhibit I-1.

[8] This Provider Number is assigned to Illinois Masonic Medical Center, the provider at issue.

[9] This list was described as days for patients identified at the time of admission as having secondary Medicaid eligibility or coverage, but for which no payment was received from either Medicare or Medicaid.

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the Provider to make any further claim (in an appeal of a revised NPR pursuant to AR) requesting additional days not previously claimed or reviewed.

The Board majority found that because the new listing of an additional 2,244 days in the current appeal (from a revised NPR) were not considered by the Intermediary when the cost report was revised, then these particular days fall outside the scope of the revised Intermediary determination. The Board majority cites to HCA Health Services of Oklahoma, Inc. v. Shalala in support of its position.

In HCA Health Services of Oklahoma, Inc. v. Shalala, the D.C. Circuit affirmed the decision of the district court which upheld the PRRB's interpretation of the statute that the Board's jurisdiction on appeal was limited to the specific "matters adjusted by the revised NPR for which the 180-day appeals period had not yet expired." Id. at 616. The D.C. Circuit held that:

> Hearing rights before the Board challenging an intermediary's decision [on] reopening are issue-specific: The separate and distinct determination gives a right to a hearing on the matters corrected by such determination. Thus, a revised NPR does not reopen the entire cost report to appeal. It merely opens those matters adjusted by the revised NPR.

Id. at 622 (internal citations omitted).

In so finding, the Court determined that the reopening process was a creation of the regulations, authorized by the Secretary's general rule-making authority under 42 U.S.C. §§1302 and 1395hh. Id. at 618. As such, the reopening process was not governed by the provisions of §1395oo of the Medicare statute.

There is no question that the Intermediary adjusted Medicaid eligible days as a part of the reopening processed pursuant to the AR for PRRB Case No. 98-2694G. The Provider has demonstrated its dissatisfaction with the Intermediary's determination when it filed in writing a request for hearing on this issue. As such the issue or matter adjusted/corrected in the revised NPR has been properly appealed by the Provider in accordance with 42 C.F.R. §405.1835.

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Yvette C. Hayes