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: 11-0772GC & 11-0773GC

MAR 02 2016

CERTIFIED MAIL

Wade H. Jaeger
Sutter Health
Reimbursement Manager, Appeals/Litigation
P.O. Box 619092
Roseville, CA 95747

Evaline Alcantara
Noridian Healthcare Solutions, LLC
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Sutter Health 2007 DSH SSI Ratio Realignment CIRP Group; Case No. 11-0772GC
Sutter Health 2007 DSH SSI Ratio Accurate Data CIRP Group; Case No. 11-0773GC

Dear Mr. Jaeger and Ms. Alcantara,

The Provider Reimbursement Review Board ("Board") has reviewed the various documents submitted in the above-captioned appeal and determined that it does not have jurisdiction over the issue under appeal. The Board's decision is set forth below.

BACKGROUND:

On the same date, Sutter Health filed two CIRP group appeal requests with the Board for the SSI Ratio Realignment issue and the SSI Ratio Accurate Data issue, both for fiscal year end ("FYE") 2007. The same Providers were used to form both group appeals. Furthermore, the issue statements for each group are very similar, with the following exceptions.

The SSI realignment group issue statement includes the following paragraph that is not included in the SSI ratio accuracy group issue statement:

> The Provider points out that 42 C.F.R. §412.106(b) provides that the Provider may choose to use its cost reporting period instead of the Federal fiscal year. The Provider believes this part of the Medicare DSH SSI issue may be easily resolvable with the Intermediary's agreement to realign the SSI percentage from the federal fiscal year, to using the Provider's fiscal period.

The SSI ratio accuracy group issue statement includes the following paragraphs that are not included in the SSI ratio accuracy group issue statement:

> The Provider contends that CMS did not use the best data available at the time of settlement to calculate the SSI fraction because of various reasons including but not limited to: not using updated current data, using data that excluded inactive claims, retroactive claims and what is sometimes referred to as forced or manual pay claims.

> The basic premise of this part of the DSH SSI issue is that the more beneficiary patient days that have SSI the greater the DSH payment amount will be and the Provider was denied valid reimbursement because the SSI days were understated.

The rest of both issue statements address the understatement of the SSI percentage as well as the contention that the best data should be used in calculating the SSI percentage.

RECOMMENDATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2010), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the SSI Ratio Realignment issue in case number 11-0772GC because there is no final determination from which the Providers are appealing. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

As the majority of the issue statement in case number 11-0772GC is identical to that in case number 11-0773GC (i.e. everything except the realignment argument), the Providers are able to pursue that portion of the issue statement in case number 11-0773GC. The issue in case number 11-0773GC is subject to remand pursuant to CMS Ruling 1498-R and will be addressed under separate cover.

Case number 11-0772GC is hereby 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty (CW)
Michael W. Harty
Chairman

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

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

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Refer to: 10-0940GC

CERTIFIED MAIL MAR 02 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 1604
Omaha, NE 68101

RE: Jurisdictional Decision
Group Name: QRS HMA 2008 DSH SSI Percentage CIRP Group
Provider No.: Various
FYE: 2008
PRRB Case No.: 10-0940GC

Dear Mr. Ravindran and Mr. Lamprecht:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted jurisdictional impediments.

Background:

On April 19, 2010, the Provider Reimbursement Review Board ("Board") received a request from Quality Reimbursement Services, Inc., ("QRS") representing Health Management Associates (hereinafter "Providers"), requesting the formation of a group appeal. The Group requested an appeal from untimely issued Notice of Program Reimbursements ("NPR") for forty five (46) Providers with fiscal years ending in 2008. The final Schedule of Providers was received by the Board on September 15, 2014, listing 45 provider appeals.

The issue being appealed is whether the Social Security Income ("SSI") percentage used by Wisconsin Physician Services, the Medicare Contractor ("MAC"), in the Medicare Disproportionate Share Hospital ("DSH") calculation accurately accounts for all patient days that must be included in the numerator and denominator of the SSI calculation.

Board Determination:

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

In considering the matters under appeal in this case, 42 C.F.R. § 405.1835(c) (2007) holds that a provider has the right to a Board hearing for specific items claimed on its cost report if a final contractor determination is not issued within twelve months after the contractor has received the perfected cost report or amended cost report, provided the delay is through no fault of the provider. The date that is

presumed to be the date received by the contractor is the date the contractor has stamped the cost report as being received.

Providers 3, 7, 8, 14, 19-24, 26-29, 32, 33, 40, and 42

Providers 3, 7, 8, 14, 19-24, 26-29, 32, 33, 40, and 42, on the Schedule of Providers, have knowingly filed an appeal prior to the twelve month time period afforded to the MAC to issue a NPR.

The Board finds that it does not have jurisdiction over these Providers pursuant to 42 C.F.R. § 405.1835(c) (2007), as their appeal was filed prior to the time allowed to the MAC for the issuance of their NPRs. Therefore the appeals of Providers 3, 7, 8, 14, 19-24, 26-29, 32, 33, 40 and 42 are hereby dismissed.

Providers 13, 31 and 39

Providers 13, 31 and 39 on the Schedule of Providers have claimed that their NPRs were untimely issued. However these Providers have not provided any documentation to support the claim.

The Board finds that it does not have jurisdiction over these Providers because their claim of an untimely NPR cannot be validated. Therefore the appeals of Providers 13, 31 and 39 are hereby dismissed.

Provider 44, No. 50-0037

Provider No. 44 on the Schedule of Providers has claimed that its NPR was untimely issued. The only documentation sent with the appeal is a computation of the estimated financial impact. The information on the Schedule of Providers lists the submission of the cost report to the MAC as December 9, 2008, and the effective date of the final determination as December 9, 2009.

On February 8, 2012, a STAR report was faxed from Wisconsin Physician Services to the Office of Hearing for Provider No. 50-0037. The report shows that the NPR was issued on July 24, 2009. Therefore, the NPR was timely issued. No information about the NPR was provided with the appeal.

The Board finds that the Provider failed to document that they have a valid appeal from an untimely NPR therefore the Board finds it lacks jurisdiction over this Provider.

Conclusion

The Board lacks jurisdiction over Participants 3, 7, 8, 13, 14, 19-24, 26-29, 31-33, 39, 40, 42 and 44 listed on the Schedule of Providers as they have failed to document that they have a valid appeal under 42 C.F.R. § 405.1835(c) (2009).

Review of these determinations may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.[1]

[1] Providers with jurisdictionally valid appeals will be remanded pursuant to the CMS 1498-R ruling, under separate cover.

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

FOR THE BOARD:

Michael W. Harty

Michael W. Harty, Chairperson

Enclosure: Schedule of Providers

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Phone: 410-786-2671
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Refer to:

09-1406GC

MAR 02 2016

CERTIFIED MAIL

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

Beth Wills
Cahaba GBA c/o National Government Services, Inc.
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: Infirmary HS 2007 Dual Eligible Days CIRP, Case No. 09-1406GC, FYE 2007
Duane Morris/McKay Consulting DSH DE Days Bifurcation to
(1) Part A Non-Covered/Exhausted Benefits Days and
(2) Part C Days

Dear Mr. McKay and Ms. Wills:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The instant group appeal, established in 2009, framed the issue as follows:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[1]

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

1 09-1406GC Group Request for Hearing at 2, April 7, 2009.

A preliminary Schedule of Providers was attached to the Request for a Hearing naming the following Providers:

- Mobile Infirmary Medical Center (01-0113) (Direct Add)
- Infirmary West (01-0152) (Direct Add)

On June 3, 2013, the Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[2] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[3] McKay wrote that it determined that " . . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[4]

Board Determination

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

In this group case, the two participants, Mobile Infirmary Medical Center (01-0113) and Infirmary West (01-0152), filed directly from final determinations to form the Dual Eligible Days group. The group issue statement described the "matter at issue" as Dual Eligible days and clearly included the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). Therefore, the Board concludes that it will grant the bifurcation of Dual Eligible days and Part C days for the two participants in the group. The Part C days issue will be adjudicated in Case No. 16-1065GC, the Infirmary HS 2007 Part C Days CIRP. Enclosed, please find the Board's Notice of Bifurcated Group Acknowledgement.

The Dual Eligible days group, case number 09-1406GC, will be scheduled for a hearing date. The Parties will receive a Notice of Hearing and Critical Due Dates letter under separate cover.

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[2] *See* Case Management Plan Letter, Jun. 3, 2013.
[3] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[4] *Id.* at 1.

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

For the Board:

Michael W. Harty
Chairman

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

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Refer to:

09-1608GC

MAR 02 2016

CERTIFIED MAIL

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

Bruce Snyder
Novitas Solutions, Inc.
JL Provider Audit Manager
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

Re: Geisinger 2007 Dual Eligible Days CIRP, Case No. 09-1608GC, FYE 2007
Duane Morris/McKay Consulting DSH DE Days Bifurcation to
(1) Part A Non-Covered/Exhausted Benefits Days and
(2) Part C Days

Dear Mr. McKay and Mr. Snyder:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The instant group appeal, established in April 2009, framed the issue as follows:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[1]

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

1 09-1608GC Group Request for Hearing at 2, April 30, 2009.

A preliminary Schedule of Providers was attached to the Request for a Hearing naming the following Provider:[2]

- Geisinger South Wilkes Barre (39-0169) (Direct Add)

On June 3, 2009 the Representative filed a Model Form E/Direct Add for

- Geisinger Wyoming Valley Medical Center (39-0270)

On June 22, 2009 the Representative filed a Model Form E/Direct Add for

- Geisinger Medical Center (39-0006)

On June 3, 2013, the Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[3] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[4] McKay wrote that it determined that " . . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[5]

Board Determination

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

In this group case, the three participants, Geisinger South Wilkes Barre, Geisinger Wyoming Valley Medical Center and Geisinger Medical Center , filed directly from final determinations to the Dual Eligible Days group. The group issue statement described the "matter at issue" as Dual Eligible days and clearly included the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). Therefore, the Board concludes that it will grant the bifurcation of Dual Eligible days and Part C days for the three participants in the group. The Part C days issue will be adjudicated in Case No. 16-1091GC, the Geisinger 2007 Part C Days CIRP. Enclosed, please find the Board's Notice of Bifurcated Group Acknowledgement.

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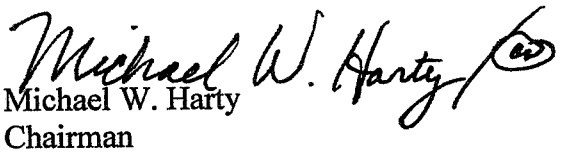
2 *See id.* at Schedule A.
3 *See* Case Management Plan Letter, Jun. 3, 2013.
4 *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
5 *Id.* at 1.

The Dual Eligible days group, case number 09-1608GC, will be scheduled for a hearing date. The Parties will receive a Notice of Hearing and Critical Due Dates letter under separate cover.

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

For the Board:



Michael W. Harty
Chairman

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

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PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

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

Refer to:

10-0110GC

MAR 03 2016

CERTIFIED MAIL

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

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

Re: University of Rochester 2006 Dual Eligible CIRP, Case No. 10-0110GC, FYE 2006
Duane Morris/McKay Consulting DSH DE Days Bifurcation to
(1) Part A Non-Covered/Exhausted Benefits Days and
(2) Part C Days

Dear Mr. McKay and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The instant group appeal, established in November 2009, framed the issue as follows:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[1]

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

[1] 10-0110GC Group Request for Hearing at 2, November 9, 2009.

A preliminary Schedule of Providers was attached to the Request for a Hearing naming the following Provider:[2]

- Highland Hospital (33-0164) (Direct Add)

On March 19, 2013 the Representative filed a Model Form E/Direct Add for

- Strong Memorial Hospital (33-0285)[3]

On June 3, 2013, the Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[4] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[5] McKay wrote that it determined that " . . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[6]

Board Determination

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

In this group case, the two participants, Highland Hospital and Strong Memorial Hospital, filed directly from final determinations to the Dual Eligible Days group. The group issue statement described the "matter at issue" as Dual Eligible days and clearly included the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). Therefore, the Board concludes that it will grant the bifurcation of Dual Eligible days and Part C days for both participants in the group. The Part C days issue will be adjudicated in Case No. 16-1096GC, the University of Rochester 2006 Part C Days CIRP. Enclosed, please find the Board's Notice of Bifurcated Group Acknowledgement.

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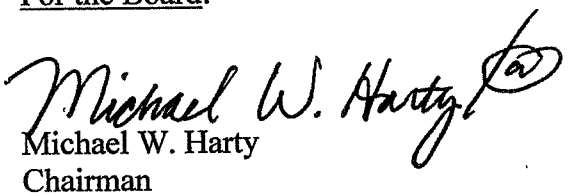
[2] *See id.* at Schedule A.
[3] The Representative submitted a corrected issue statement for this participant on April 10, 2013. The initial issue statement incorrectly referenced the SSI Percentage issue. The correction describes the issue as "Whether the Medicare/Medicaid dual eligible days are properly included in the disproportionate share calculation." The correction was filed within 180 days of the NPR.
[4] *See* Case Management Plan Letter, Jun. 3, 2013.
[5] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[6] *Id.* at 1.

The Dual Eligible days group, case number 10-0110GC, will be scheduled for a hearing date. The Parties will receive a Notice of Hearing and Critical Due Dates letter under separate cover.

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

For the Board:



Michael W. Harty
Chairman

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

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CERTIFIED MAIL

MAR 08 2016

Jordan B. Keville
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799

RE: Orange Coast Memorial Medical Center
Provider No.: 05-0678
FYE: 6/30/04
PRRB Case No.: 07-2232

Dear Mr. Keville,

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's request to transfer the Dual Eligible Days issue to a group appeal and withdraw the case. The Board's determination is set forth below.

Background

The Provider timely filed an appeal on June 11, 2007 from a Notice of Program Reimbursement ("NPR") dated December 18, 2006. The Provider initially raised four issues in its appeal request and subsequently raised a fifth issue by letter dated June 25, 2007 as follows:

1. Supplemental Security Income ("SSI") Percentage;
2. Medicaid Percentage – Medicaid Eligible Days;
3. Unbilled Crossover Bad Debts;
4. Settlement Data;
5. Rural Floor Budget Neutrality Adjustment ("RFBNA").

The Board remanded the DSH SSI issue to the Medicare Contractor on May 28, 2014 pursuant to CMS Ruling 1498-R. The Provider subsequently requested a remand for the Labor and Delivery Room ("LDR") Days issue, but on December 7, 2015, the Board found that it did not have jurisdiction over LDR days as this issue had not been timely raised or added to the appeal.

The Provider requested transfer of the RFBNA issue to Case No. 07-2288GC and the Crossover Bad Debt issue to Case Nos. 99-3578GC (outpatient) and 09-1764GC (inpatient). In November 2015, the Provider also requested to transfer the Dual Eligible Days issue to PRRB Case No. 13-3960GC – MHS 7/1/2003 – 9/20/2004 Dual Eligible CIRP Group.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2007), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is 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 regulations require that:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position.[1]

PRRB Rules elaborate on this regulatory requirement as follows:

> You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect…You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[2]

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835 (2008) 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.[3] In practice this means that new issues had to be added to pending appeals by October 20, 2008.

The regulations at 42 C.F.R. § 405.1868 denote possible Board actions in response to failure to follow Board rules:

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[1] 42 C.F.R. § 405.1841 (2007).
[2] Provider Reimbursement Review Board Rules (2002), Part I § B.II.a., http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.
[3] *See* 73 FR 30,236 (May 23, 2008).

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

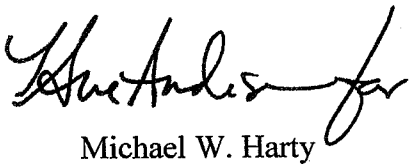
Upon review of the record in this appeal, the Board finds that the Dual Eligible Days issue was not specifically raised in the original appeal request, nor subsequently added to the appeal. As such, the Board does not have jurisdiction over the issue as it is not properly in the appeal. Accordingly, the Board denies the Provider's request to transfer the Dual Eligible Days issue to PRRB Case No. 13-3960GC.

The Board acknowledges the proper transfers of the RFBNA issue to Case No. 07-2288GC and the Crossover Bad Debt issue to Case Nos. 99-3578GC (outpatient) and 09-1764GC (inpatient). The Medicaid Eligible Days and Settlement Data issues remain in the appeal, with a scheduled hearing date of March 21, 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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD



Michael W. Harty
Chairman

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

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

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

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

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

Refer to: 06-0080GC

CERTIFIED MAIL

MAR 11 2016

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

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Reopening of Bifurcation Denial
CHW 1998 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 06-0080GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's")[1] request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the CHW 1998 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days CIRP Group. The Board initially granted bifurcation for three Providers in the appeal in its November 7, 2014 Decision. Upon reconsideration, the Board hereby grants bifurcation for all of the Providers in this appeal, as explained below.

Background

On October 7, 2005, the Board received Toyon's group appeal request regarding DSH dual eligible days. The group was initially comprised of two providers but following multiple transfer and withdrawal requests, Toyon's final Schedule of Providers, dated July 7, 2010, consists of 15 providers.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its November 7, 2014 Decision, the Board granted bifurcation of the issues for Participants 2, 3, and 8 only and established case number 15-0248GC for the Medicare HMO days issue. The Board also confirmed that it had previously denied the transfer requests for Participants 1 and 4 to this group. This appeal was then remanded to the Medicare Contractor on July 14, 2015 pursuant to CMS Ruling 1498-R and the appeal was closed.

Toyon has since submitted this Request for Reopening of Bifurcation Denial in which it has

[1] Toyon is the providers' representative for this appeal.

requested that the Board reopen and reverse its determination denying the Providers' request to bifurcate the dual eligible and HMO days issues.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Although the Board initially denied Toyon's request for case bifurcation for all but three Participants in the group, the Board has decided to grant the request for Reopening in order to grant bifurcation for the remaining Providers in the group. The Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeal request were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 06-0080GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[2] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Board hereby reopens case number 06-0080GC in order to bifurcate the Part C Days issue from this appeal for all of the Providers remaining in the group. The Providers' Part C issue is now within PRRB Case No. 15-0248GC. The Providers' dual eligible Part A non-covered days issue has already been remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R on July 14, 2015. As the Part C days issue has been transferred to case number 15-0248GC and the dual eligible days issue in this appeal has been remanded, case number 06-0080GC is hereby closed.

Please submit an updated Schedule of Providers and jurisdictional documents in case number 15-0248GC within 45 days of the date of this letter.

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.

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

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

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
Schedule of Providers dated June 15, 2010

cc: Wilson Leong, Federal Specialized Services

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

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

Refer to:

12-0618GC

CERTIFIED MAIL

MAR 16 2016

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

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

Re: Catholic Healthcare Partners 2000-2001 DSH Dual Eligible Days CIRP Group
PRRB Case No. 12-0618GC

Duane Morris/McKay Consulting DSH DE Days Bifurcation to
(1) Part A Non-Covered/Exhausted Benefits Days and
(2) Part C Days

Dear Mr. McKay and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The instant group appeal, established in September 2012, framed the issue as follows:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[1]

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

[1] 12-0618GC Group Request for Hearing at 2, September 17, 2012.

The Representative attached a preliminary Schedule of Providers for FYE 2000 to the Request for a Hearing, naming providers:

- Riverside Hospital (36-0094) Transferred from optional group 04-1872G.[2]
- St. Charles Hospital (36-0081) Transferred from optional group 05-2172G.[3]
- St. Vincent Medical Center (36-0112) Transferred from optional group 04-1872G[4]

On June 3, 2013, the Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5]

On August 9, 2013, the Representative requested the transfer of two additional participants from an optional group for FYE 2001 to case no. 12-0618GC:

- St. Charles Hospital (36-0081) Transferred from optional group 05-2173G[6]
- St. Vincent Medical Center (36-0112) Transferred from optional group 05-2173G[7]

On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[8] McKay wrote that it determined that "'. . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction.'"[9] All five participants are on both the Dual Eligible Days and Part C Days Schedules of Providers.

Board Determination

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

---

[2] Provider initially transferred Dual Eligible days issue from individual appeal 04-0875 to optional group 04-1872G on July 7, 2004.
[3] Provider initially transferred Dual Eligible days issue from individual appeal 04-1061 to optional group 05-2172G on August 23, 2006.
[4] Provider initially transferred Dual Eligible days issue from individual appeal 04-0793 to optional group 04-1872G on August 22, 2006.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] Provider initially transferred Dual Eligible days issue from individual appeal 04-2272 to optional group 05-2173G on November 7, 2005.
[7] Provider initially transferred Dual Eligible days issue from individual appeal 05-2054 to optional group 05-2173G on November 7, 2005.
[8] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[9] *Id.* at 1.

Prior to the 2008 regulatory change which limited the ability to add issues to an open appeal, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Although the five providers in this case requesting bifurcation of the Part C days issue did not originally raise the sub-issue of Part C days in their original individual appeals (all of which were filed prior to the 2008 Rule change), the initial requests to transfer the Dual Eligible days issue to optional group appeals also occurred prior to the 2008 regulation change. Seemingly, the groups appealed multiple issues, since the groups' definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). Therefore, the Board deems the "transfer" of the "Dual Eligible days component" a transfer of Dual Eligible Exhausted Benefits days and an "add/transfer" of the Dual Eligible Part C days issue. The Board finds that the optional group appeals to which the providers initially transferred explicitly defined the issue under appeal as including the Part C days component and hereby grants the bifurcation of Dual Eligible days and Part C Days issues.

The Part C days issue will now be adjudicated in Case No. 16-1198GC, the Catholic Healthcare Partners 2000-2001 Part C Days CIRP. Enclosed, please find the Board's Notice of Bifurcated Group Acknowledgement.

Also enclosed is a Standard Remand Pursuant to CMS Ruling 1498-R for the Dual Eligible days group.

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: Board's Notice of Bifurcated Group Acknowledgement for case no. 16-1198GC & Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R

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

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

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

CERTIFIED MAIL

MAR 16 2016

Stephanie A. Webster
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036-1532

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

RE: Memorial Hermann Katy Hospital
Provider No.: 45-0847
FYE: 12/31/2006
PRRB Case No.: 08-2831

Dear Ms. Webster and Mr. Tisdale,

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

Background

The Provider filed a timely appeal request on August 28, 2008 containing three issues, including bad debt not returned from an outside collection agency, bad debt based on patient's indigent status, and bad debt that was uncollectible but held less than 120 days. On October 17, 2008, the Provider submitted a request to add two issues to the appeal including understatement of Medicaid eligible days for DSH and understatement of SSI ratio for DSH.

On April 30, 2009, the Provider submitted a Preliminary Position Paper that only addressed the bad debt issues. Similarly, the Medicare Contractor submitted a Preliminary Position Paper on August 20, 2009 that only addressed the bad debt issues. On August 19, 2009, the Provider submitted a request to transfer the SSI ratio issue to the Memorial Hermann Hospital System 1999-2006 SSI CIRP Group, PRRB Case No. 09-0735GC.[1] On January 24, 2014, the parties submitted a partial administrative resolution that resolved the bad debt based on the bad debt issues related to the patient's indigent status and the bad debt that was uncollectible but held less than 120 days. The issue of bad debts not returned from an outside collection agency was transferred to PRRB Case No. 16-0125GC on February 18, 2016.

The Medicare Contractor filed a jurisdictional challenge on the Medicaid eligible days issue on July 18, 2013. The Medicare Contractor contends that there was no audit adjustment to the Medicaid eligible days on the Provider's 12/31/06 Medicare Cost Report, thus no final determination specific to this issue.[2] The Medicare Contractor also notes that the Provider failed to address this issue in its

[1] The Board closed Case No. 09-0735GC on November 3, 2010 pursuant to an alternative remand under CMS Ruling 1498-R.

Preliminary Position Paper dated April 30, 2009, even though the issue was added to the appeal six months before the Preliminary Position Paper was filed.[3] The Provider responded to the Medicare Contractor's jurisdictional challenge on August 22, 2013. The Provider responded to Board Alert 10 on July 22, 2014, addressing the Medicare Contractor's argument regarding unclaimed days.

Board's Decision

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

The regulations at 42 C.F.R. § 405.1868 denote possible Board actions in response to failure to follow Board rules:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Board notes that Board Rule 25[4] provides that preliminary position papers are expected to present the fully developed positions of the parties. Rule 25.1 A. states that the text of the Preliminary Position Paper must include for each issue, the material facts supporting the claim, the controlling authority, and a conclusion applying the material facts to the controlling authorities.

In the instant case, the Board finds that the Provider did not brief the Medicaid eligible days issue in its Preliminary Position Paper. As such, the Board finds that the Provider abandoned its claim on the Medicaid eligible days, and dismisses the issue from the appeal. Accordingly, the Board need not

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[2] Medicare Contractor's Jurisdictional Challenge at 3.
[3] *Id.* at 4.
[4] Provider Reimbursement Review Board Rules (2008), Part II, Rule 25, http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

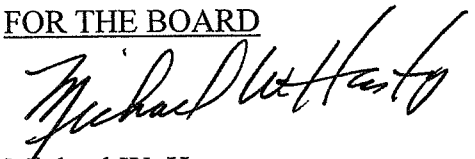
address the Parties' arguments with respect to unclaimed Medicaid eligible days as the issue is not in the appeal.

Upon the dismissal of the Medicaid eligible days issue, the Board notes that there are no issues remaining in the appeal. The Board hereby closes PRRB Case No. 08-2831 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.

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

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: 16-0350

CERTIFIED MAIL

MAR 21 2016

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

RE: Jurisdictional Decision – Centennial Medical Center
Provider No.: 44-0161
FYE: 12/31/2013
PRRB Case No.: 16-0350

Dear Ms. Browne,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for hearing. The Board finds that Centennial Medical Center's hearing request was not timely filed. The decision of the Board is set forth below.

Background

On May 29, 2014, the Medicare Administrative Contractor ("MAC") received Centennial Medical Center's cost report. On November 27, 2015, Centennial Medical Center's hearing request was received by the Board.

Board's Decision

The Board, on its own motion, finds that it does not have jurisdiction over this appeal because the request for hearing was not timely filed in accordance with the rules associated with the non-issuance of a Provider's Notice of Program Reimbursement ("NPR").

Pursuant to 42 C.F.R. § 405.1835(c)(2), unless the provider qualifies for a good cause extension under 42 C.F.R. § 405.1836, the date of receipt by the Board of the Provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of that section). Paragraph (c)(1) states, inter alia, that a provider has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting if a final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) *within 12 months after the date of receipt* by the contractor of the provider's perfected cost report (emphasis added).

As the Provider acknowledges in its hearing request, "the MAC *received* the Provider's cost report on May 29, 2014 (emphasis added).[1]" Although the Provider states that the MAC "acknowledged that it had accepted the provider's cost report on June 20, 2014[2]," neither acknowledgement nor acceptance of the Provider's cost report are the triggering events to start the clock for the one year and 180 day filing requirement for a hearing request. The date from which the one year and 180 day filing deadline must be calculated is, therefore, May 29, 2014.

For the Provider's filing of its hearing request to be considered timely, the hearing request needed to be received by the Board by no later than November 25, 2015 which is one year and 180 days from May 29, 2014. The Provider's hearing request was sent via Federal Express to the Board on November 25, 2015. It was not, however, received by the Board until November 27, 2015 which is 182 days after the expiration of the 12 month period for the issuance of the final determination[3].

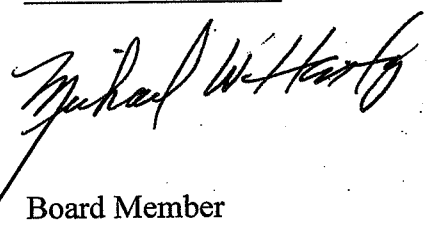
The Provider incorrectly contends that "the appeal is timely filed within 180 days of the MAC's 12 month period for NPR issuance[4]" and does not make any assertion or offer any evidence that it would qualify for a good cause extension under 42 C.F.R. §405.1836.

Since the Provider did not timely file its hearing request and the Board finds that it does not have jurisdiction, the Provider's individual appeal is hereby dismissed.

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

FOR THE BOARD:



Board Member

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

[1] Tab 3, page 4 of Provider's hearing request in "Statement of Jurisdiction" section.
[2] *Ibid*
[3] The date of receipt by the reviewing entity under 42 C. F. R. § 405.1801 is the date of delivery.
[4] Tab 3, page 4 of Provider's hearing request in "Statement of Jurisdiction" section.

cc: Cahaba GBA c/o National Government Services, Inc.
Beth Wills
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

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

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

Refer to: 09-1763GC

MAR 23 2016

CERTIFIED MAIL

Delbert W. Nord
Quality Reimbursement Services
Senior Consultant
112 N. University Rd.
Suite 308
Spokane Valley, WA 99206

Lee Crooks
Noridian Healthcare Solutions – WA/AK
6505 216th Street SW, Suite 205
Mountlake Terrace, WA 98043

RE: QRS University of Washington Medicine 2006-2007 SSI CIRP Group
Provider No.: Various
FYE: Various
PRRB Case No.: 09-1763GC

Dear Mr. Nord and Ms. Crooks,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Providers' representative's argument that the appeal is not subject to remand pursuant to CMS Ruling 1498-R. The Board finds that the appeal is subject to remand. The decision of the Board is set forth below.

BACKGROUND:

Case number 09-1763GC was established on May 26, 2009 for the SSI percentage issue. The group representative, Quality Reimbursement Services, Inc. ("QRS"), requested to establish this group with a participant that was previously in case number 09-0222GC, QRS University of Washington Medicine 1991-1993, 1995, 1998 Medicare DSH SSI% CIRP Group. QRS stated in the appeal request that for FYEs ending in 2005 and after, the regulations changed and necessitated the need to appeal a SSI sub-issue that is not applicable for years prior to 2005. QRS later clarified that this appeal was established for FYEs beginning on or after 10/1/2004 because of the effective date of 42 C.F.R. § 412.106.[1]

The Board issued a letter to the Providers requesting an updated Schedule of Providers and jurisdictional documentation, and indicating that the file was to be reviewed pursuant to CMS Ruling 1498-R. When QRS submitted the Schedule of Providers, it argued that the issue under appeal is not subject to remand as the Board indicated.

[1] The change instructed Medicare contractors to include Medicare Advantage days in the SSI fraction.

PROVIDERS' POSITION:

The Providers argue that the issue in case number 09-1763GC is not subject to remand pursuant to CMS Ruling 1498-R. The Providers state that the appeal is for cost reports ending in 2006 and 2007 and that the new data matching process has already been implemented and applied for those FYEs. According to the Providers, they have already received new SSI percentages from which they are appealing, so the cost reports do not need to go back to the Medicare Contractor for new percentages.

BOARD'S DECISION:

Jurisdictional Impediment

Although the Medicare Contractor did not file a jurisdictional challenge in this appeal, the Board finds that it does not have jurisdiction over Participant 1, University of Washington (provider no. 50-0008, FYE 6/30/2006). Participant 1 did not timely request to add the SSI percentage issue to its individual appeal prior to requesting to transfer the issue to this group. . Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835 (2008) 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.

Participant 1 was issued its Notice of Program Reimbursement ("NPR") on November 12, 2008. The Provider had 180 days plus the 5 day mailing presumption, or until May 16, 2009, to file its individual appeal request with the Board. The Provider had another 60 days, or until July 15, 2009, to add issues to its appeal. The Provider timely filed its individual appeal request, but did not timely add the SSI percentage issue; the issue was not mentioned until its August 21, 2009 transfer request. Therefore, the Board finds that it does not have jurisdiction over Participant 1, University of Washington (provider no. 50-0008, FYE 6/30/2006) and hereby dismisses the Provider from this appeal.

Group Issue Subject to Remand

The Board finds that the issue and FYEs under appeal in case number 09-1763GC are subject to remand pursuant to CMS Ruling 1498-R. The Providers argue that they are appealing from new SSI percentages that were issued as a result of the ruling, however that is not the case.

CMS has issued new SSI percentages for FYEs 2006 and 2007, the FYEs under appeal in this group; however, those percentages were issued on March 16, 2012.[2] Each of the Providers had already been issued an NPR, appealed the SSI percentage issue, and transferred the issue to this group appeal before the date CMS issued the new SSI percentages to Providers.

CMS issued a Medicare Learning Network ("MLN") Matters issue on June 22, 2012, which indicated that new SSI percentages were available for FYs 2006-2009. The MLN Matters also said that for FYs 2006 and 2007, Medicare contractors would issue revised NPRs for any cost reports that were previously final settled. The Providers in this group are all appealing from original NPRs that were issued in either 2008 or 2009. These Providers' cost reports were final settled prior to the issuance of the new SSI percentages, therefore in order to be appealing the new SSI percentages, the appeal would need to be from a revised NPR.

The Board finds that the Providers are appealing from SSI percentages that are subject to remand pursuant to CMS Ruling 1498-R. The remand will be addressed under separate cover.

Review of these determinations 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, not participating
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson

FOR THE BOARD

Charlotte Benson

Board Member

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

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

[2] Medicare Learning Network Matters Number SE 1225 (June 22, 2012), *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1225.pdf

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

Refer to:

08-1645GC

CERTIFIED MAIL and E-MAIL

MAR 29 2016

Toyon Associates, Inc.
Thomas P. Knight
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546
tom.knight@toyonassociates.com

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782
jeprrbappeals@noridian.com;jameslowe@CSALLC.com

RE: Request for Reopening
NorthBay Health Group 2004 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-1645GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to NorthBay Health Group's ("NorthBay's") January 15, 2016 Request for Reopening ("Request"). Within its Request, NorthBay asks the Board to reconsider its April 29, 2015 determination that denied NorthBay's request for issue bifurcation in the instant appeal. Following reconsideration, the Board hereby grants NorthBay's request for case bifurcation of the disproportionate share hospital ("DSH") dual eligible Part A non-covered and Part C days issues for the participants within this group, as explained below.

Background

The Board received NorthBay's request to form a common-issue related party ("CIRP") group appeal on March 21, 2008. The group appeal is comprised of two participants' individual appeals, both challenging the Medicare contractor's treatment of DSH dual eligible days in their respective fiscal year end ("FYE") December 31, 2004 cost reporting periods. NorthBay's issue statement contained within the instant CIRP group appeal documents the following common-issue:

> Whether the Medicaid Ratio used to calculate Medicare [DSH] accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A program but is not entitled to Medicare Part A benefits.

The Board issued an April 29, 2015 jurisdictional determination in which it denied NorthBay's request to bifurcate its dual eligible Part C days "sub-issue" from the dual eligible no Part A payment days issue. Within its determination, the Board concluded that after "review of the issue statement . . . the Board finds that there is no mention of Medicare Part C Days as a sub-issue . . . [t]herefore, the Board denies [NorthBay's] request to bifurcate and establish [a] separate Part C Days group[ ]."[1]

On August 18, 2015, the Board issued a "Standard Remand of the Medicare Dual Eligible Days Under [the Centers for Medicare & Medicaid Services ("CMS")] Ruling CMS-1498-R" for NorthBay's appeal of its dual eligible no Part A payment days issue for the time period January 1, 2004 through September 30, 2004.[2] Within its remand letter, the Board stated that "[t]he remaining period from 10/1/2004 to 12/31/2004 for the two participants in the group is being consolidated into case number 08-1655GC . . ."[3] and that it was closing the instant appeal, PRRB Case Number 08-1645GC.

The Board received NorthBay's January 15, 2016 Request in which NorthBay argues that the Board should "reopen and reverse its determination denying the Providers' request to divide the . . . DSH appeal between Medicare Part A and Part C dual-eligible days . . ."[4]

Board's Reconsideration Decision

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

Accordingly, the Board finds that, for the time period January 1, 2004, through September 30, 2004, there are two issues pending within PRRB Case No. 08-1645GC in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, reinstating PRRB Case No. 08-1645GC in order to bifurcate the dual eligible Part A non-covered and Part C days issues. The participants' Part C issue will be transferred into the newly formed PRRB Case No. 16-1298GC. The participants' dual eligible Part A non-covered days issue was previously remanded pursuant to CMS-1498-R and, therefore, after the bifurcation, the instant appeal will once again be closed.

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[1] Board's April 29, 2015 Determination at 2.
[2] Under the terms of CMS-1498-R, providers' appeals of dual eligible, no Part A payment days from cost reporting periods with discharges before October 1, 2004, are subject to the mandatory remand procedures set out within CMS-1498-R.
[3] In response to NorthBay's July 17, 2015 Reconsideration Request for PRRB Case No. 08-1655GC, the Board granted NorthBay's dual eligible issue bifurcation request on March 21, 2016, including the time period October 1, 2004, through December 31, 2004, for the two participants originally contained within the instant group appeal.
[4] Request at unnumbered 1.
[5] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Group Acknowledgment Letter for PRRB Case No. 16-1298GC
Schedule of Providers dated July 28, 2015

cc: Wilson Leong, Federal Specialized Services

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

Refer to: 06-2095GC

CERTIFIED MAIL

MAR 31 2016

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

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Reopening of Bifurcation Denial
Catholic Healthcare West 1994 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 06-2095GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's")[1] request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the Catholic Healthcare West ("CHW") 1994 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Common Issue Related Party ("CIRP") Group. The Board initially denied bifurcation of the issues in a decision issued on November 7, 2014. Upon reconsideration, the Board hereby grants bifurcation for all of the remaining Providers in the appeal, as explained below.

Background

On August 7, 2006, the Board received Toyon's group appeal request regarding DSH dual eligible days. The group was initially comprised of two providers but following its multiple transfer and withdrawal requests, Toyon's final Schedule of Providers, dated December 21, 2012, consists of four providers.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its November 7, 2014 Decision, the Board denied bifurcation of the issues for all Providers in the group. The Board also dismissed Participants 2 and 3[2] from this appeal for lack of jurisdiction. This appeal was then remanded to the Medicare Contractor on June 30, 2015 pursuant to CMS Ruling 1498-R and the appeal was closed.

[1] Toyon is the Providers' representative for this appeal.
[2] Marian Medical Center (provider no. 05-0107, FYE 11/30/1994) and Mercy General Hospital (provider no. 05-0017, FYE 3/31/1994).

Toyon has since submitted this Request for Reopening of Bifurcation Denial in which it has requested that the Board reconsider its decision to deny bifurcation of the issues for the two Providers that have jurisdictionally valid appeals pending in this group.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (1997), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

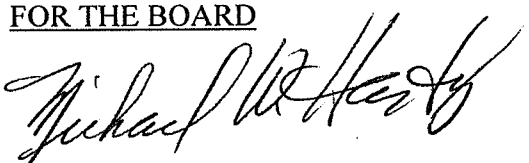
Although the Board initially denied Toyon's request for case bifurcation, the Board has decided to grant the request for Reopening in order to grant bifurcation for the two remaining Providers in the appeal. The Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 06-2095GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues. The Board hereby reopens case number 06-2095GC in order to bifurcate the HMO Days issue from this appeal and transfer the issue to newly established PRRB Case No. 16-1301GC, Catholic Healthcare West 1994 HMO Days CIRP Group. The Providers' dual eligible Part A non-covered days issue has already been remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R on June 30, 2015. As the HMO days issue has now been transferred to case number 16-1301GC and the dual eligible Part A non-covered days issue in this appeal has been remanded, case number 06-2095GC is once again closed. The Board's Acknowledgment Letter for PRRB Case No. 16-1301GC is included as an enclosure along with this determination.

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

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

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

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated December 12, 2010
Group Acknowledgement Letter for PRRB Case No. 16-1301GC

cc: Wilson Leong, Federal Specialized Services