Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

St. Dominic-Jackson Memorial Hospital
(CCN: 25-0048),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-173

ALJ Ruling No. 2016-12

Date: June 15, 2016

ORDER OF DISMISSAL

I dismiss the hearing request of Petitioner, St. Dominic-Jackson Memorial Hospital, because it has no right to an administrative law judge (ALJ) hearing. Specifically, Petitioner is not seeking review of an action that is subject to ALJ review. 42 C.F.R. §§ 498.3, 498.5.

I. Background and Procedural History

Petitioner is a hospital in Jackson, Mississippi, that is enrolled in the Medicare program. In October 2013, Petitioner submitted a Form CMS-855A to its Medicare Administrative Contractor, Novitas Solutions (Novitas). Petitioner's Exhibit (P. Ex.) 1. Petitioner stated that the purpose of the enrollment application was to change its Medicare information (P. Ex. 1 at 9), to include its identifying information, practice location information, payment address, medical record storage information, and authorized officials. P. Ex. 1 at 10. In Section 4 of the enrollment application, Petitioner indicated that it would be adding a hospital psychiatric unit, effective January 1, 2014. P. Ex. 1 at 27. That same month, Petitioner sent a letter to the Mississippi State Department of Health (DOH) requesting an exception from the Medicare Prospective Payment System (PPS) for the upcoming fiscal year beginning January 1, 2014. P. Ex. 3 at 1. Petitioner included an

attestation statement and a Psychiatric Unit Criteria Work Sheet (Form CMS-437) indicating it was requesting an exclusion for the cost reporting period from January 1, 2014, to December 31, 2014. P. Ex. 3 at 2-11.

On January 17, 2014, Novitas informed Petitioner that it needed to make revisions to its CMS-855A and provide supporting documentation within 30 days. P. Ex. 4. After receiving Petitioner's response, in a letter dated February 17, 2014, Novitas informed Petitioner that it had assessed Petitioner's Medicare enrollment application and sent it to both the DOH and the Atlanta Regional Office of the Centers for Medicare & Medicaid Services (CMS). P. Ex. 6.

In August 2014, Petitioner submitted a Determination of Reviewability Application Form to the DOH for the "Establishment of Geriatric Psychiatric Distinct Part Unit." P. Ex. 7. In its submission, Petitioner was "requesting authority to establish a twenty-six (26) bed distinct-part geriatric psychiatric unit ("Geropsych unit")." P. Ex. 7 at 1. Petitioner further explained that it intended to use adult psychiatric licensed beds in the Geropsych unit and that it would be located in a distinct part of the hospital that is physically separate from other psychiatric beds not included in the unit. P. Ex. 7 at 1. On October 15, 2015, the DOH informed Petitioner that "the proposed project will not be in compliance under Mississippi Code Annotated 41-7-191, et seq. (1972) (Supp. 1972)," and that "the Department is not authorized to approve adult psychiatric beds as licensed acute care beds, as proposed in the project." P. Ex. 8 at 2. In closing, the DOH informed Petitioner that a certificate of need (CON) would be required for Petitioner's project.[1] P. Ex. 8 at 2.

In November 2014, Petitioner re-submitted a Determination of Reviewability Application Form to the DOH, at which time it significantly modified its request and no longer sought to establish a Geropsych unit. P. Ex. 9 at 1-2. Whereas the first proposal indicated

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[1] The DOH letter referenced Appendix F of the DOH's Certificate of Need Review Manual. Appendix F is entitled "Guidelines for Establishing a Medicare Certified, Distinct Part, PPS-Excluded Psychiatric Unit for Geriatric Psychiatric Patients in Mississippi Acute Care Hospitals," and that appendix details the requirements for establishing a distinct part geriatric psychiatric unit. *See http://msdh.ms.gov/msdhsite/_static/resources/3346.pdf* (last visited June 10, 2016). Appendix F directs that "the beds to be included in the proposed unit will remain licensed acute care beds." Petitioner had stated in its application that it did not plan "to convert acute care licensed beds to be used in the Geropsych unit as contemplated in Appendix F of the Certificate of Need Review Manual." P. Ex. 7 at 1.

Petitioner was seeking approval to establish a distinct part geriatric psychiatric unit, the November 2014 application indicated that Petitioner "will not restrict the treatment in the [distinct part unit] to patients of a particular age or payer source." P. Ex. 9 at 3.

On May 7, 2015, the DOH informed Petitioner that it had approved Petitioner's request to establish a 26-bed psychiatric distinct part unit. P. Ex. 10. Specifically, the DOH concluded that "because St. Dominic will provide the same service, and the beds will remain licensed as adult psychiatric beds," it would "approve adult psychiatric beds as licensed adult psychiatric beds as proposed in the above project (establishment of Psychiatric Distinct-Part Unit (26-Bed Unit))." P. Ex. 10 at 2. The letter explained that Petitioner had 83 psychiatric beds, and that it could convert 26 of those beds to beds in the 26-bed unit, which would have its own medical director and head full-time nurse. P. Ex. 10 at 1-2. Petitioner subsequently, in June 2015, submitted a new Attestation Statement for Exclusion from PPS for Fiscal Year Beginning **January 1, 2016.** P. Ex. 11 at 2 (emphasis in original).

CMS informed Petitioner that its enrollment application and request for exclusion of the distinct part psychiatric unit was granted, with an effective date of January 1, 2016. CMS assigned Petitioner a sub-provider certification number (CCN). CMS Exhibit (CMS Ex.) 1.

Petitioner challenged the effective date assigned, January 1, 2016, in its request for hearing. I issued an Acknowledgment and Pre-Hearing Order on December 29, 2015. On March 28, 2016, CMS filed a motion to dismiss, with two supporting exhibits (CMS Exs. 1-2). Petitioner filed a response to the motion to dismiss, along with 19 exhibits (P. Exs. 1-19).[2]

II. Issues

The general issue here is whether I should dismiss Petitioner's hearing request, to specifically include whether the determination of the effective date for exclusion of Petitioner's distinct part psychiatric unit from PPS is an initial determination that is subject to ALJ review.

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[2] Petitioner also submitted a brief in which it addressed the merits of the instant case. However, since I have granted CMS's motion to dismiss, it is unnecessary to address Petitioner's arguments on the merits.

III. Discussion[3]

CMS contends that I lack the authority to hear this case, whereas Petitioner argues that it has appealed a reviewable initial determination that is within my jurisdiction. For the reasons explained herein, I conclude that I lack jurisdiction over the instant case.

1. The assignment of the effective date for the exclusion of Petitioner's distinct part psychiatric unit from PPS is not a reviewable initial determination.

This case is governed by 42 C.F.R. Part 498, which gives providers and suppliers the right to appeal certain CMS actions. Petitioner is a provider of services, and the term "provider of services" means "a hospital, critical access hospital, skilling nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(h) and section 1835(e), a fund." 42 U.S.C. § 1395x(u). Pursuant to 42 C.F.R. § 498.3(a)(1), an initial determination regarding one of the matters specified in 42 C.F.R. § 498.3(b) may be appealed such that a provider or supplier is entitled to a hearing before an ALJ and Departmental Appeals Board (Board) review of the ALJ decision. *See Vijendra Dave, M.D.,* DAB No. 2672 at 10 (2016). One of the matters listed in section 498.3(b) includes "[t]he effective date of a Medicare provider agreement or supplier approval," and Petitioner contends that it is entitled to a hearing pursuant to 42 C.F.R. § 498.3(b)(15). The issue at hand involves Petitioner's request for exclusion from PPS, which is a system of Medicare reimbursement for providers. 42 C.F.R. § 412.20(a) (stating that "all covered hospital inpatient services furnished to beneficiaries during the subject cost reporting periods are paid under the prospective payment system as specified in § 412.1(a)(1)"). Petitioner, by creating a new distinct part psychiatric unit, was seeking reimbursement for that unit's covered services outside of PPS.

Petitioner contends that it "filed a Medicare Enrollment Application ("Form CMS-855A") with Novitas," and "this provider application is appealable and was effectively denied when CMS assigned an effective date of January 1, 2016, instead of the January 1, 2014 as originally sought by St. Dominic's in the application." P. Br. at 1, 6. Petitioner further argues that 42 C.F.R § 498.5 provides appeal rights if an existing provider is dissatisfied with an initial determination or revised initial determination related to the denial or revocation of billing privileges. P. Br. at 3-4. Petitioner also contends that several decisions of the Board support the proposition that a provider or supplier has a right to challenge the effective date of enrollment, to include a provider agreement or

[3] My findings of fact and conclusions of law are in bold and italic font.

supplier approval.[4] P. Br. at 5, citing *Eugene Rubach, M.D.,* DAB CR2125 at 3 (2010) (which in turn references a number of other ALJ decisions). Petitioner argues that the letter from CMS notifying it that its distinct part unit had been approved is an initial determination pursuant to 42 C.F.R. § 498.3(b)(15).

Section 498.3(b)(15) states that the "effective date of a Medicare provider agreement or supplier approval" is an initial determination. While Petitioner asserts that section 498(b)(15) is applicable, it has not demonstrated that the effective date of its *provider agreement* with Medicare was impacted by its request for an exclusion from PPS of its distinct part psychiatric unit. When Petitioner first informed CMS that it would be adding a new "practice location" to its hospital, its enrollment application stated that this unit would be a practice location *under the same provider agreement* that was already in effect. P. Ex. 1 at 9-10. In fact, the instructions on the Form CMS-855A enrollment application state that "[i]f a provider agreement is not required, the location can be added as a practice location," but that if the provider was adding a practice location "and the location requires a separate provider agreement, a separate, complete CMS-855A must be submitted for that location. The location is considered a separate provider for purposes of enrollment, and is not considered a practice location of the main provider." P. Ex. 1 at 20; *see* Form CMS-855A, Section 4 Instructions, *https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf,* last visited June 10, 2016. Petitioner, in its Form CMS-855A, simply added a new practice location to its existing enrollment information that was previously on file with CMS. In its application, Petitioner indicated that it was changing its Medicare information, to include identifying information, practice location information, payment address, and medical record storage information, and authorized officials; Petitioner did not, in any way, indicate that it was attempting to add a separate practice location that would require a separate provider agreement. P. Ex. 1. As nothing in Petitioner's October 2013 enrollment application initiated a new Medicare provider agreement, Petitioner has no basis to challenge the "effective date of a Medicare provider agreement" as stated in section 498.3(b)(15). *See* 42 C.F.R. § 489.3 (defining a provider agreement as "an agreement between CMS and one of the providers specified in § 489.2(b) to provide services to Medicare beneficiaries and to comply with the

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[4] I observe that all decisions cited by Petitioner in support of its arguments consist of decisions by individual ALJs and not decisions by panels of the Board. In citing to these decisions, Petitioner is correct that a provider can challenge the effective date of a provider agreement pursuant to 42 C.F.R. § 498.3(b)(15). However, in the instant case, section 498.3(b)(15) is not an applicable provision of law.

requirements of section 1866 of the [Social Security] Act"). Petitioner has presented no evidence that, as a result of CMS's approval of its update to its enrollment information in October 2013, it entered into a new provider agreement with a new effective date.[5]

The Board has previously concluded that the creation of a PPS-excluded unit under similar circumstances did not give rise to a new provider agreement. The Board has explained that 42 C.F.R. § 412.25 "sets forth the requirements for PPS excluded hospital units" and "states that in order to be excluded, a distinct part . . . unit must: 'Be part of an institution that—(1) Has in effect an agreement under part 489 . . . to participate as a hospital . . . .'" *Metropolitan Methodist Hospital,* DAB No. 1694 at 3 (1999) (emphasis omitted). The Board explained in *Metropolitan* that the hospital "was already qualified as a 'hospital' to provide inpatient services under Medicare when it sought the PPS exclusion" and that "[n]either the statute nor the regulations recognize distinct part . . . units of hospitals as independent providers of inpatient hospital services." *Id.* The Board further explained that the petitioner had not sought to have the distinct part unit certified as a provider separate from Metropolitan, and that "services excluded under PPS" is not a category of appealable covered services under the Act. *Id.*; *see also Specialty Hospital of Southern California – La Mirada,* DAB No. 1730 (1999) (explaining that the assignment of a new provider number of the PPS-excluded unit "did not affect the status of either entity as a hospital or the type of services that either entity provided" but rather "the change reflected what reimbursement methodology would apply.").

While Petitioner is displeased that it took nearly two years to ultimately obtain DOH and CMS approval of its PPS-excluded distinct part psychiatric unit, I have determined that dismissal is warranted and I lack jurisdiction over the matter.[6] However, I will briefly

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[5] The State Operations Manual, while not binding on these proceedings, explains that a "PPS excluded psychiatric unit is part of the hospital and is included as part of the overall hospital survey" and the "term 'exclusion' is a *reimbursement term*." State Operations Manual, Appendix A (emphasis added).

[6] It may be possible for Petitioner to pursue this case through another entity. *See* Medicare Provider Reimbursement Manual, Chapter 30, Section 3006 (stating that a hospital has a right to appeal certain determinations to the Provider Reimbursement Review Board (PRRB)). *See Metropolitan Methodist Hospital,* DAB No. 1694 (stating that section 1878 of the Social Security Act and Part 405, Subpart R, of the Medicare regulations authorize review by the PRRB of certain types of provider reimbursement determinations). Section 3001 of the Provider Reimbursement Manual addresses the instant situation and states: "A determination of excluded or nonexcluded status for a hospital or hospital unit applies to the entire cost reporting period for which the determination is made. ROs make these determinations, generally on an annual basis. If

address Petitioner's arguments. Petitioner previously proposed that it would create a Geropsych unit, and apparently based on this proposal, the DOH determined that a CON was necessary. *See* P. Ex. 7; P. Ex. 8, citing M.C.A. § 41-7-191 et seq. (1972) (Supp. 1972). After Petitioner amended its proposal to serve "patients of all ages," the DOH determined that a CON was no longer necessary. P. Exs. 9, 10. The DOH approved Petitioner's significantly revised proposal in May 2015 (P. Ex. 10), and CMS subsequently approved Petitioner's request for PPS exclusion of the distinct part unit and assigned a January 1, 2016 effective date for approval of the excluded unit, which was the first day of the new cost reporting period. CMS Ex. 1.

Petitioner's distinct part psychiatric unit was not approved by the DOH until May 7, 2015. P. Ex. 10. The regulations indicate that there are numerous requirements for CMS approval of an excluded psychiatric unit pursuant to 42 C.F.R. § 412.27, to include the broad areas of development of assessment/diagnostic data, psychiatric evaluations, treatment plans, recording progress, discharge planning and discharge summary, personnel, director of inpatient psychiatric services, medical staff, nursing services, psychological services, social services, and therapeutic activities. Additionally, an excluded psychiatric unit must meet the common requirements outlined in 42 C.F.R. § 412.25, to include:

> *Changes in the status of hospital units.* For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined . . . at the start of the cost reporting period. *If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next reporting period.*

42 C.F.R. § 412.25(c) (emphasis added). The regulation regarding excluded hospitals and hospital units, 42 C.F.R. § 412.22(d), mirrors this language, stating:

> For purposes of exclusion from the prospective payment systems under this subpart, the status of each currently participating hospital (excluded or not excluded) is determined at the beginning of each cost reporting period and is

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a change in meeting applicable criteria occurs during a cost reporting period, the status already determined for that period remains in effect for the duration of the period. The change in the hospital's or unit's status (e.g., from excluded to not excluded) takes effect only at the start of the next cost reporting period."

> effective for the entire cost reporting period. *Any changes in the status of the hospital are made only at the start of a cost reporting period.*

(emphasis added). The applicable regulations indicate that changes to a hospital unit's PPS exclusion will occur at the *start* of a cost reporting period, and that the status at the beginning of a cost reporting period remains in effect for the entire cost reporting period. The DOH did not approve Petitioner's request to establish a distinct part psychiatric unit until May 7, 2015 (P. Ex. 10), and CMS in turn granted an exclusion from PPS beginning at the start of the next cost reporting period that began on January 1, 2016.

2. I lack jurisdiction to hear this case.

As previously explained, 42 C.F.R. § 498.3(b)(15) is inapplicable, and the October 2015 CMS approval of Petitioner's request for PPS exclusion of its distinct part psychiatric unit is not an appealable initial determination. *See Metropolitan, supra.*

IV. Conclusion

I lack jurisdiction over Petitioner's request for hearing. Therefore, I dismiss Petitioner's hearing request.

_________/s/_______________
Leslie C. Rogall
Administrative Law Judge