PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D36

PROVIDER -Dominguez Valley Hospital
Long Beach, CA

Provider No. 05-0034

vs.

INTERMEDIARY -
Ætna Life Insurance Company

DATE OF HEARING-
February 19, 1998

Cost Reporting Period Ended -
May 31, 1989

CASE NO. 93-0337

INDEX

ISSUE:

Was the Provider's request for an adjustment to the TEFRA target amount for the 1989 fiscal year filed on a timely basis?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

General Facts:

Dominguez Valley Hospital ("Provider") was a 272-bed, short-term general hospital located in Long Beach, California, during the fiscal year at issue. During the same fiscal year, the Provider was a wholly owned subsidiary of National Medical Enterprises, Inc., which is now known as Tenet Healthcare Corporation.

Using the 1985 fiscal year as the TEFRA base period, Ætna Life Insurance Company ("Intermediary") applied a TEFRA target amount of $4,554.17 per discharge to the Provider's psychiatric unit for the fiscal period ending May 31, 1989. The application of this limit caused the actual costs per discharge to exceed the TEFRA target amount for the 1989 fiscal year by $167,924. A Notice of Program Reimbursement (NPR) reflecting the impact of the rate of increase ceiling on the 1989 cost reporting period was issued by the Intermediary on September 23, 1991.

Because of the substantial impact of the TEFRA limit on the Provider's reimbursement for psychiatric services furnished to Medicare patients during the 1989 fiscal year, the Provider timely requested an exemption from the rate of increase ceiling pursuant to the provisions of 42 C.F.R.
§ 413.40, in a letter to the Intermediary, dated March 20, 1992.[1] The March 20, 1992 letter specifically asked the Intermediary to consider the Provider's 1989 fiscal year as the new TEFRA base year for the new 40-bed psychiatric unit in light of the significant differences in the severity of illness of patients treated in the unit in 1989 as compared to that of the patients for the previous years, especially the 1985 base year.

In the March 20, 1992 letter, the Provider emphasized that the patients in the 18-bed intensive treatment area of the 40-bed psychiatric unit "[r]equired a much greater intensity of nursing services than the other psychiatric patients, including the other Medicare psychiatric patients."[2] As a result, the Provider explained that the average cost per discharge for the unit in 1989 was significantly higher than the average cost per discharge during previous fiscal years, especially during the 1985 base year when there was no intensive psychiatric treatment furnished.

---

1 Provider Exhibit P-1.

2 Id.

In June 1992, in response to the Provider's March 20, 1992 letter, the Health Care Financing Administration ("HCFA") notified the Intermediary of its decision regarding the Provider's request for exemption to the rate of increase ceiling. HCFA confirmed that the 40-bed psychiatric unit should be excluded from the Medicare Prospective Payment System (PPS) under 42 C.F.R
§ 412.25 of the Medicare regulations. However, HCFA refused to grant the Provider an exemption from the TEFRA rate of increase ceiling for the 1989 fiscal year because HCFA determined that the Provider did not meet the requirements for designation as a new hospital under the rate of increase ceiling pursuant to 42 C.F.R. § 413.40(f)(1).

The Provider contends that HCFA's June 1992 letter[3] did not fully address its request for a changed base year or other relief resulting from the fact that the average cost of treating patients in the 40-bed unit was substantially greater than the average cost of treating patients in previous periods due to the addition of the intensive treatment subunit to the psychiatric unit.

Based on the its contention that the June 1992 HCFA letter did not respond to all of the points raised in its March, 1992 TEFRA appeal letter, the Provider requested "reconsideration" of the March 20, 1992 request in a second letter to the Intermediary, dated December 16, 1992.[4] The Provider's request for reconsideration, made pursuant to 42 C.F.R. § 413.40(e)(4), emphasized that the intensive nursing services required by patients in the 18-bed intensive treatment section of the 40-bed psychiatric unit was substantially greater than the intensity of the services required and furnished in previous years, especially during the 1985 base year, and thus argued that an adjustment to the TEFRA rate of increase ceiling be granted pursuant to 42 C.F.R.
§ 413.40(g)(3).

The Provider's December 16, 1992 request for reconsideration was forwarded to HCFA by the Intermediary. By letter dated March 29, 1994[5] HCFA chose not to reconsider its initial determination that the Provider did not qualify as a "new hospital," and further indicated that the Provider's request for a cost comparability adjustment under 42 C.F.R. § 413.40(g)(3)(ii) could not be considered because it had not been timely filed, i.e., it was not filed within 180 days of the NPR for the 1989 fiscal year.

The Provider appealed HCFA's denial of the request for reconsideration by amending its

---

3 Provider Exhibit P-2.

4 Provider Exhibit P-3.

5 Provider Exhibit P-4.

original December 16, 1992 appeal letter to the Provider Reimbursement Review Board ("Board"), on April 11, 1994.[6]

The Provider filed a timely appeal of HCFA's denial determination with the Board pursuant to 42 C.F.R. §§ .1835-.1841. The Medicare reimbursement amount in dispute is $167,294.[7] The Provider is represented by Patric Hooper of Hooper, Lundy & Bookman, Inc., and the Intermediary is represented by Marshall Treat, of Mutual Of Omaha.[8]

Background:[9]

During the 1985 and 1986 fiscal years, the Provider's licensed beds included a 28-bed psychiatric unit where routine psychiatric services were furnished to Medicare and other patients. By the beginning of the 1989 fiscal year, the Provider's operation of the psychiatric unit had changed from a single 28-bed unit to two subunits totaling 40 beds -- (1) a 22-bed routine psychiatric unit, and (2) an 18-bed locked, intensive treatment unit. The patients treated in the 18-bed locked subunit were more seriously ill than the patients treated in the previous 28-bed psychiatric unit and the then-current 22-bed routine subunit.

The original 28-bed psychiatric unit had been excluded from the Medicare Prospective Payment System ("PPS") for the 1985 and 1986 fiscal years. The TEFRA base year for the 28-bed unit had been the 1985 fiscal year. During the 1987 and 1988 fiscal years, the psychiatric unit was not excluded from the PPS payment system. Rather, payment for psychiatric services furnished to Medicare patients in the psychiatric unit during the 1987 and 1988 fiscal years was made to the Provider under the PPS system based on the applicable DRGs.

As of the beginning of the 1989 fiscal year, a 22-bed routine subunit and an 18-bed locked subunit were required to be treated as a single 40-bed psychiatric cost center for Medicare reimbursement purposes. The single cost center was excluded from the PPS system as of the commencement of the 1989 fiscal year pursuant to 42 C.F.R. § 412.22. Thus, the Medicare reimbursement for services furnished in the 40-bed combined psychiatric unit was governed by the reasonable cost reimbursement principles of 42 C.F.R. § 413.1 for the 1989 fiscal year.

---

6 The Provider also filed an earlier "protective" appeal with the Board of the original HCFA denial on December 16, 1992. It amended the original Board appeal on April 11, 1994. See Provider Exhibits P-5 & P-6.

7 Provider Position Paper at 2, Intermediary Position Paper at 2.

8 Since the original appeal was filed, the case was transferred to from Aetna Life Insurance Company to Mutual Of Omaha.

9 Provider Proposed Decision Brief at 2-3.

As a result, the TEFRA ceiling on the rate of hospital cost increase, 42 C.F.R. § 413.40, was applicable to the 1989 fiscal year.

Relevant Medicare Statutory and Regulatory Background:

Pursuant to 42 C.F.R. § 413.40(e), a hospital may request an exemption from, or adjustment to, the rate of cost increase ceiling imposed under 42 C.F.R. § 413.40. The hospital's request must be made to its fiscal intermediary no later than 180 days after the date of the intermediary's notice of amount of program reimbursement.

Ordinarily, the fiscal intermediary then refers the request to HCFA after making a recommendation about the request. HCFA must ultimately issue a decision to the intermediary no later than 180 days after receipt of the completed application for relief from the rate of increase ceiling and the intermediary's recommendation thereon. 42 C.F.R. § 413.40(e)(2).

The fiscal intermediary is to notify the hospital of the decision, including a full explanation of the grounds for the decision. The determination is then considered to be final for purposes of further review, i.e., review with the PRRB, unless the hospital submits additional information and requests reconsideration/review by HCFA no later than 180 days after the date the intermediary notifies the provider of HCFA's initial determination. 42 C.F.R. § 413.40(e)(4).

The time required for filing and processing the request and any review of the request for relief, including any request for a reconsideration of the original decision, is considered to be "good cause" for granting an extension of the time limit to appeal a notice of program reimbursement with the PRRB. 42 C.F.R. § 413.40(e)(5) and (6).

"Exemptions" from the TEFRA limit include exemptions for new hospitals under 42 C.F.R. § 413.40(f). "Adjustments" to the TEFRA limit include situations in which factors cause a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits. 42 C.F.R. § 413.40(g)(3). Those factors include "increases in service intensity" attributable to changes in the type of patients serviced. 42 C.F.R. § 413.40(g)(3)(ii)(D).

PROVIDER'S CONTENTIONS:

The Provider contends that its request for relief from the TEFRA rate of increase ceiling for the 1989 fiscal year was timely filed. Specifically, the Provider filed its original request with the fiscal Intermediary within 180 days of the issuance of the Notice of Program Reimbursement for the 1989 fiscal year. The Provider points out that while it characterized its March 20, 1992 letter as a "request for exemption," the substance of the letter constitutes a request for an adjustment due to the substantial change in the intensity of services attributable to the changes in the types of patients served in the 40-bed psychiatric unit in 1989 compared

to the patients treated in the previous 28-bed unit.[10] Therefore, because of the change in intensity of services, the Provider contends that the costs necessarily incurred by the Provider during the 1989 fiscal period to treat psychiatric patients in the 40-bed unit were materially greater than the costs necessarily incurred to treat the psychiatric patients during the 1985 TEFRA base year.

The Provider further contends that HCFA's June, 1992 denial of the relief requested in the March 20, 1992 letter did not adequately respond to the primary issue raised in the request. Rather, HCFA treated the March 20, 1992 request as if it was a request for a new hospital exemption in order to make the psychiatric unit exempt from the TEFRA rate of increase ceiling for the 1989 fiscal year. The Provider believes the HCFA response missed the point of the March 20, 1992 request. Therefore, because HCFA's determination (which was not received by the Provider until June 30, 1992) was basically nonresponsive to the main points raised in the March 20, 1992 request, the Provider argues that on December 16, 1992 it timely requested reconsideration of its initial denial adding the fact that it was requesting an adjustment under 42 C.F.R. § 413.40(g), due to the lack of comparability of cost reporting periods referred to in its initial request.

The Provider asserts the thrust of its initial request for relief from the application of the rate of increase ceiling for the 1989 fiscal year was that the intensity of services and additional expenses of providing services to psychiatric patients during the 1989 fiscal year were materially greater than the intensity of services and the corresponding average costs of providing psychiatric services to patients during the 1985 fiscal year. However, the 1985 fiscal year was used by the Intermediary as the TEFRA base year for purposes of determining the allowable rate of increase in the ceiling limit for the 1989 fiscal year. The Provider explains that one solution proposed in its March 20, 1992 letter was to make the 1989 fiscal year the new TEFRA base year since the 1989 fiscal year reflected the costs of the intensive care unit. An alternative solution to assigning a new base year would be an adjustment due to the lack of comparability of cost reporting periods.

The Provider contends its original request adequately furnished HCFA with the information necessary to grant either form of relief. However, rather than addressing the issues presented in the original request, HCFA responded by denying a request for an exemption as a new hospital. The Provider contends this reply was completely nonresponsive to its request. Thus, the Provider asserts it was fully justified in requesting reconsideration. However, rather than reconsidering its initial denial, HCFA chose to deny the request for reconsideration and to hold that any request for the assignment of a new base period or an adjustment due to the lack of comparability of cost reporting periods was untimely requested. According to HCFA, the request for an adjustment was not included in the original TEFRA appeal request. The Provider contends there is absolutely no basis in fact or in the regulation to support HCFA's decision in this regard.

---

[10] Provider Position Paper at 7.

The Provider concludes by asserting that (1), because the initial request for relief was timely filed and, (2), the request for reconsideration was timely filed, there is no basis for concluding, as HCFA did, that the request for relief under 42 C.F.R. § 413.40(g) was untimely, or that the request for a changed base year was filed untimely.

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the Provider has filed two distinct and separate Requests for Exception. The Intermediary asserts the Provider's first request was that FYE May 31, 1989 should be established as a base period for a newly established certified unit. HCFA, in a decision received by the Intermediary on June 30, 1992, denied the Provider's request inasmuch as the Provider did not meet the criteria established in 42 C.F.R. § 413.40(f)(1).

The Intermediary contends that the Provider subsequently changed its tactic and filed a new request which it characterized as a reconsideration request. The Intermediary maintains the language and assertions in the Provider's December 16, 1992 request are significantly, if not dramatically different than the language used in the Provider's original request. The Intermediary asserts the language in the December 16, 1992 letter requesting reconsideration does not address nor challenge the HCFA determination of June 30, 1992.[11]

The Intermediary contends that the thrust of the Provider's December 16, 1992 letter is a change in tactic from one provision of 42 C.F.R. § 413. to another. The Intermediary asserts the position mentioned in the Provider's December 16 letter was not raised in prior communication by the Provider to the Intermediary/HCFA.[12]

The Intermediary contends that it is clear that the Provider failed to meet the timeliness requirements and that its request of December 16, 1992 is invalid for lack of timeliness. Therefore, the Intermediary maintains the HCFA determination of March 29, 1994 is valid and proper.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTION:

1. Law - 42 U.S.C.:

§ 1395ww(b)	-	TEFRA Rate of Increase Ceiling

---

[11] Intermediary Position Paper at 4.

[12] Id.

2. Regulations - 42 C.F.R.:

§ 412.22	-	Excluded Hospitals and Hospital Units: General Rules
§ 412.25	-	Excluded Distinct Part Hospital Units: Common Requirements
§ 413.1	-	Reasonable Cost
§ 413.40 et seq.	-	Ceiling on Rate of Hospital Increases
§ 1835-.1841(b)	-	Extension of Time Limit for Good Cause

3. Cases:

Palo Verde Hospital vs. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Arizona, PRRB Decision No. 98-D3, October 24, 1997, Medicare & Medicaid Guide (CCH), ¶ 45,738, vacated and remanded, HCFA Administrator, December 29, 1997

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, the Parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that the Provider's initial request to the Intermediary regarding the applicability of the TEFRA rate of increase was filed in a timely manner in accordance with 42 C.F.R. § 413.40 (e)(1). Under that provision, a hospital may request an exemption from, or adjustment to, the rate of cost increase ceiling imposed under 42 C.F.R. § 413.40, by filing its request with its fiscal Intermediary no later than 180 days after the date of the Intermediary's Notice of Program Reimbursement. The Board finds the Intermediary issued a Notice of Program Reimbursement (NPR) for the subject cost reporting period on September 23, 1991, and the Provider timely (within 180 days) requested relief from the rate of increase ceiling on March 20, 1992.

HCFA responded to this request in June, 1992 by indicating that since the Provider did not qualify as a new hospital, the psychiatric unit at issue here could not be exempted from the TEFRA rate of increase ceiling for the 1989 fiscal year. After the Intermediary's decision, the Provider filed a reconsideration request on December 16 which clarified its initial request and also provided additional information. It is the Board's opinion that this request did not materially change the Provider's arguments presented in its first request. The reconsideration

request was filed pursuant to 42 C.F.R. § 413.40 (e)(4), which states

> *Notification and review* The Intermediary notifies the hospital of the decision, including a full explanation of the grounds for the decision. A decision issued under paragraph (e)(2) or (e)(3) of this section is considered final unless the hospital submits additional information no later than 180 days after the intermediary's notice of the decision.....

42 C.F.R. § 413.40(e)(4).

The Board finds that the Provider submitted additional information and clarified its position within 180 days related to HCFA's denial of its March 20, 1992 request.

Moreover, the Board notes that § 413.40(e)(5) provides that the appeal of a TEFRA exception is considered good cause for an extension of the 180-day period for appeal from an NPR:

> (5) *Extending time limit for PRRB review of NPR* . The time required to review the request is considered good cause for the granting of an extension of the time limit to apply for review of the notice of amount of program reimbursement by the Provider Reimbursement Review Board, as specified in 405.1841(b) of this chapter.

Id.

It appears to the Board that the timeliness comments under § 413.40(e) apply to §§ 413.40(f), *Exemptions*, (g), *Adjustments*, and (i), *Assignment of a new base period*.

The Board observes that the Provider was under PPS for 2 years before the year in question. The Board notes that the evidence shows that in the Provider's request of March 20, 1992, it applied for an exemption because of PPS, however, the request also provided arguments in favor of an adjustment. The March 20 letter emphasized, among other things, that the patients in the Provider's psychiatric unit during the 1989 fiscal year required much more intensive psychiatric services than the patients who received treatment during the TEFRA base year, the 1985 fiscal year. As a result, the Provider contended that the cost of furnishing services to patients during the 1989 fiscal year necessarily increased more than the allowable target rate increases between 1985 and 1989. Thus, the Provider asserted that it was entitled to relief, including a change in the TEFRA base year for the 1989 fiscal year.

The Board makes reference to the HCFA Administrator's decision in ("Palo Verde"). In Palo Verde, the HCFA Administrator stated,

> [F]urther, Section 413.40(g)(3)(iii) permits HCFA to adjust the operating costs subject to the TEFRA rate of increase ceiling without a formal request to do so to take into account adjustments including, but not limited to, the adjustment

> for malpractice insurance costs not included in the base year operating costs set forth at 413.(g)(ii)(C).

Palo Verde, CCH ¶ 45,738 (emphasis added).

In the instant case, the Provider had requested a new base year due to factors that caused a distortion between the subject year and the 1985 base year. Although the Provider characterized the request as an exemption, which HCFA denied, § 413.40(g)(3)(iii) permits HCFA to adjust the operating costs without a further request, i.e. based on the merits of the documentation provided in the exemption request.

The Board also notes that in Palo Verde, the HCFA Administrator points out that 42 C.F.R. § 413.40(e)(5) provides that the appeal of a TEFRA exception is considered good cause for an extension of the 180-day period for appeal from an NPR. In Palo Verde, the provider was well beyond the 3 year limit as specified in 42 C.F.R. § 405.1841(b). The Board interprets these points made by the Administrator in Palo Verde to mean that if a provider has a valid TEFRA exception request pending, (as it did in Palo Verde), it could add an issue to its appeal beyond the 180 day limit. This contradicts the Intermediary's contention that the Provider "added" a new issue to its TEFRA appeal beyond 180 days from the NPR date and was therefore untimely. Based on the above, the Board rejects the Intermediary's contention that the purported "new issue", added by the Provider in its December 16, 1992 reconsideration request, was untimely due to the fact that it was beyond the 180 day limit. Even if it was a new issue, which the Board does not believe it was, § 413.40(e)(5) provides for extending the 180 day limit while a valid TEFRA appeal is pending.

The Board, under the particular facts of this case, finds and concludes that, (1) because the Provider's March 20, 1992 request for TEFRA relief was timely, and, (2) because the Provider's December 16, 1992 "reconsideration" request, providing additional information was also filed timely, HCFA should have concluded that both requests were timely and made a decision on the Provider's request based on the substance of the Provider's initial documentation. As stated above, pursuant to 42 C.F.R. § 413.40(g)(3)(iii), HCFA could have adjusted the Provider's operating costs subject to the TEFRA rate of increase ceiling without a formal request. Although the Provider had initially requested a new base year, via an exemption, which was denied by HCFA, the Board believes that the Provider had submitted enough information for HCFA to make a decision on the Provider's request for relief. The Provider's request for a new base year, based on an increase in intensity of services, should have been construed by HCFA as a request for an adjustment which should have been addressed in HCFA's initial denial. As the HCFA Administrator indicated in Palo Verde, HCFA had the authority to adjust a provider's operating costs subject to the TEFRA rate-of-increase ceiling without a formal request. In the case at hand, the Provider had in fact submitted a formal request. If HCFA had acted on the substance of the Provider's initial request, there would have been no question as to timeliness.

DECISION AND ORDER:

The Provider's request for an adjustment to the TEFRA target amount for the 1989 fiscal was filed on a timely basis. The case is remanded to HCFA for a ruling on the merits of the Provider's request as set forth in its initial request and its request for reconsideration.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: March 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman