PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D27

PROVIDER -
St. Joseph Hospital
Houston, Texas

Provider No. 45-0035

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
January 12, 1999

Cost Reporting Period Ended -
June 30, 1989

CASE NO. 94-2772

INDEX

ISSUE:

Was the denial of the Provider's request for an adjustment to the TEFRA limits because of untimely filing, proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider is a distinct part psychiatric unit of St. Joseph Hospital, a general acute care hospital located in Houston, Texas. The Provider has been excluded from the Medicare prospective payment system since its certification, and is reimbursed for services on the basis of reasonable and allowable costs, subject to the limits imposed by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").

The Intermediary issued a Notice of Program Reimbursement ("NPR") for the June 30, 1989 Medicare cost report year on May 22, 1991.[1] In that settlement, inpatient operating costs exceeded the TEFRA target amount by $ 579,639.[2] A revised settlement resulted in inpatient operating costs exceeding the target amount by $ 658,710.[3]

On November 18, 1991, the 180th day after May 22, 1991, the Provider mailed a letter to the Intermediary stating that the Provider was requesting an adjustment to the TEFRA limits in accordance with 42 C.F.R. § 413.40. The Provider also stated in its letter that it was in the process of preparing a detailed position paper and it anticipated that it would be submitted within 90 days. The Provider also requested that an Intermediary representative "[p]lease sign below and return one copy ... to certify that this request has been filed in a timely manner and the timing of the submittal of our detailed position paper will be acceptable." The letter was signed by an Intermediary representative on December 5, 1991.[4] This letter was mailed by certified mail, return receipt requested and the return receipt reflected that the request was received by the Intermediary on November 22, 1991.[5] On September 8, 1992 the Provider submitted the detailed position paper to support its request for an adjustment to the TEFRA

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[1] Exhibit I-1.

[2] Exhibit I-2.

[3] Exhibit I-3.

[4] Exhibit P-2.

[5] Exhibit P-3.

limits for fiscal year 1989.[6]On January 7, 1994 (the 1993 date on the letter is incorrect) the Intermediary determined that the Provider was entitled to an adjustment of $656,969 and reopened the Provider's cost report.[7] However, on February 22, 1994 HCFA denied the Provider's request for an adjustment on the basis that it was not received within 180 days of the date of the NPR. HCFA asserts that the request was signed by the Intermediary representative on December 5, 1991 and was stamped with a receipt date of December 9, 1991.[8] On March 9, 1994 the Intermediary notified the Provider of HFCA's denial.[9] This was followed by a notice dated March 31, 1994, wherein the Intermediary notified the Provider of its intent to revise the cost report to take back the $ 656,959 previously paid.[10]

On April 4, 1994, the Provider filed an appeal with the Provider Reimbursement Review Board ("Board"), and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Mr. Manie W. Campbell of Campbell Wilson. The Intermediary was represented by Mr. Marshall J. Treat of Mutual of Omaha.

PROVIDER'S CONTENTIONS:

The Provider's NPR is dated May 22, 1991. On November 18, 1991, the 180th day following the date of the NPR, the Provider mailed its request for an adjustment to the TEFRA limits by certified mail, return receipt requested. The request was received by the Intermediary on November 22, 1991, the 184th day following the date of the NPR.

The Provider contends that the regulations at 42 C.F.R. § 413.40(e) indicate that a request for an adjustment "must be made to its fiscal intermediary no later than 180 days after the NPR date." The Provider contends that the request was made when it was mailed and, therefore, the request was timely. HCFA contends that the request was not made until it was received by the Intermediary. And since it was not received until the 184th day after the date on the NPR, the request was not timely.

The Provider contends that the only issue involved in this appeal is the timeliness of its adjustment request. HCFA is not contending that the November 18, 1991 request was merely a "letter of intent" to file an adjustment request. HCFA clearly states this in a January 16, 1995 letter:

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6 Exhibit P-4.

7 Exhibit P-5.

8 Exhibit P-6.

9 Exhibit P-7.

10 Exhibit I-8.

> [t]o restate our determination of February 22, 1994 and March 30, 1994, we are denying the request for an adjustment to the rate of increase limit for FYE 1989 due to untimely filing. We did not suggest to the intermediary that the application was denied for any other reason. Correspondence written by the intermediary should not have stated that the request was denied because the hospital submitted a one page letter of "intent to file" an exception application.

Id.

The regulation provided that the request "must be made" to the intermediary within 180 days of the NPR date. The Provider notes that the regulation was amended, effective October 1, 1995, to require that the request be received by the intermediary within the 180-day period. The preamble to the regulation states that "use of the word made . . . has resulted in varying interpretations of the timely filing requirements by hospitals and their fiscal intermediaries." See 60 Fed. Reg. 45,840 (Sept. 1, 1995). Thus, HCFA has acknowledged that prior to this amendment in 1995, there were different interpretations by hospitals and intermediaries regarding when a request was made.

In fact, at the time the Provider mailed its request it was the Intermediary's interpretation that the request was made within the meaning of 42 CFR § 413.40(e). The Provider, in its request, asked the Intermediary to sign the request to certify that it had been filed in a timely manner. That the Intermediary signed the request establishes the Intermediary's interpretation that the request was made when it was mailed.[11]

The Provider also notes that in the preamble to the 1995 amendment, HCFA states that it is appropriate to examine the provisions regarding the filing of an appeal request because such a request, like an adjustment request, involves a provider seeking reimbursement in addition to thatset forth in its NPR. HCFA stated that its policy with regard to the timely filing of an exception request should be consistent with its policy regarding the filing of an appeal request.[12] Section 1878(a)(3) of the Social Security Act provides that a provider must file an appeal request within 180 days after notice of the intermediary's final determination. The regulations at 42 C.F.R. § 405.1801(a) then state that the date of filing is the day of mailing as evidenced by the postmark. HCFA then quotes the definition of "file" from Black's Law Dictionary and concludes that an exception request will be considered filed when it is received by the Intermediary. Thus, HCFA's policy regarding the filing of an exception request is not consistent with its policy regarding the filing of an appeal request.

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[11] Exhibit P-2.

[12] 60 Fed. Reg. 45,841 (September 1, 1995).

The Provider also notes that the date of filing a cost report is the day of mailing as evidenced by the postmark. See HCFA Pub. 13-2 § 2219.4C. Thus, at the time the Provider mailed its request, there was no guidance as to when the request was made. There were, however, the two provisions referenced above that dealt with the filing of documents regarding the Medicare program. Both pointed to mailing as the controlling date. There was nothing to indicate that the rules would be different for adjustment requests. The Provider contends that in light of HCFA's failure to provide guidance, it should be allowed to rely on these analogous authorities in determining when its request was made. In fact, HCFA has admitted that its policy regarding the filing of an adjustment request should be consistent with its policy regarding the filing of an appeal request. The Provider contends that it should not be penalized when its interpretation of the regulation is reasonable, consistent with that of its Intermediary and in accordance with analogous authority.

To support its position that its adjustment request was timely made, the Provider relied upon a decision of the Board in which it addressed the issue of whether a reopening request that was mailed within the required three-year period but received by the intermediary after the three-year period was timely made. See Providence Hospital (Oakland, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D22, February 13, 1995, Medicare & Medicaid Guide(CCH), ¶ 43,081, rev'd. HCFA Admin. April 4, 1995, Medicare & Medicaid Guide(CCH), ¶ 43,262. The governing regulation, 42 CFR § 405.1885(a), provides that the reopening request "must be made within 3 years of the date of notice of the Intermediary determination." The Board held that the provider's request was timely, finding that the provider's request was made when it was mailed. The HCFA Administrator reversed the Board's decision on the basis that the provider's request was not complete. However, in footnote 4, the Administrator states that "[t]he Administrator notes that the provider's request to reopen was timely, and that the Intermediary did not raise the issue of timeliness in its comments." Id.

The Provider contends that this same rationale should apply to TEFRA requests as 42 C.F.R. § 413.40(e) also used the term "made." There is no reason for HCFA to treat a reopening request as "made" when it is mailed to the Intermediary and a TEFRA request as "made" when it is received by the Intermediary. Accordingly, the Provider contends that its TEFRA request was made when it was mailed and, therefore, was timely.

The Provider also notes the case of University Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, PRRB Case No. 94-2299. (Settled prior to Board hearing). It is the Provider's understanding that in this case the provider mailed its request for a TEFRA adjustment on the 180th day from the date of its NPR and the request was initially rejected on the basis that it was not received within the 180-day period. The case was settled and the basis for settlement was that HCFA and the intermediary agreed that the request was timely made within the meaning of 42 CFR § 413.40(e).

Finally, the Provider refers to the recent Board decision in Deaconess Medical Center (Spokane, WA.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 98-D43, April 22, 1998, Medicare & Medicaid Guide (CCH) ¶ 46,269, rev'd. HCFA Admin. June 19, 1998. In that case the Board held that a request for a TEFRA target rate adjustment was timely filed because it was submitted for delivery with the U.S. post office within the 180-day limitations period. Prior to its revision in 1995, the text of 42 C.F.R. § 413.40 did not state expressly that a TEFRA exception request had to be received by the intermediary within the 180-day limitations period. The Board determined that a standard that employs the U.S. postal service and requires an item to be date stamped or postmarked the day it was submitted for delivery is a fair and equitable way to document the tender of TEFRA exception requests by applicants.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that a TEFRA exception request must be made and received within 180 days of the issuance of the NPR. In the instant case, the Provider failed to do so by filing a letter of intent 184 days beyond the NPR date. The language of 42 C.F.R. § 413.40(e) states " . . . a hospital may request an exemption from, or exception or adjustment to, the rate of cost increase ceiling imposed under this section. The hospital request must be made to its fiscal intermediary no later than180 days from the date on the intermediary's notice of program reimbursement . . ." (Emphasis added).

The Intermediary contends that HCFA has consistently interpreted the word "made" to mean received by the fiscal intermediary since the original regulation was promulgated (47 Federal Register 43282, September 30, 1992). Also, Black's Law Dictionary defines "file" as in filing a request to mean " a paper is said to be filed when it is delivered to the proper officer, and by him received to be kept on file as a matter of record and reference." Id. Also, the request for an exception process referred to in 42 C.F.R. § 413.40 makes reference to an "application." In this case, the full application was not submitted until September 8, 1992, which was also beyond the 180 day limit specified by the regulation. The Provider has not presented an adequate explanation as to why the original request for exception was not within the 180-day requirement nor why the full application took more than a year past the NPR date to file.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law-Title XVIII of the Social Security Act:

§ 1878(a)(3)	-	Provider Reimbursement Review Board

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

§ 405.1801(a)	-	Definitions
§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885(a)	-	Reopening a determination or decision
§ 413.40	-	Ceiling on the rate of increase in hospital inpatient costs
§ 413.40(e)	-	Hospital regulations regarding adjustments to the payment allowed under the rate of increase ceiling

3. Program Instructions- Intermediary Manual (HCFA Pub. 13-2):

§ 2219.4C	-	Proof of Receipt

4. Cases:

Providence Hospital (Oakland, CA) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D22, February 13,1995, Medicare & Medicaid Guide (CCH), ¶ 43,081, rev'd. HCFA Admin. April 4, 1995, Medicare & Medicaid Guide (CCH),¶ 43,262.

University Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, PRRB Case No. 94-2299.(Settled prior to Board hearing).

Deaconess Medical Center (Spokane, WA.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 98-D43, April 22, 1998, Medicare & Medicaid Guide (CCH) ¶ 46,269, rev'd. HCFA Admin. June 19, 1998.

Reserve Ins.. Co. v. Duckett, 238 A 2d. 536 (D. Md. 1968).

Morrison v. Thoelke, 155 So. 2d 889 (D. Fla. 1963).

5. Other:

47 Fed. Reg. 43,282 (1992)
60 Fed. Reg. 45,840 (1995)
60 Fed. Reg. 45,841 (1995)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds and concludes that the Provider properly applied 42 C.F.R. § 413.40. Thus, the Provider "made" its request for an appeal once it placed the request in the U.S. mail. This initiated a chain of irreversible events once the request was placed in the hands of a legally recognized agent, the United States Post Office. The regulation at 42 C.F.R. § 413.40(e) (1987) specifically states in part:

> (e)Hospital requests regarding applicability of the rate of increase ceiling. A hospital may request an exemption from, or exception to, the rate of cost increase ceiling imposed under this section. The hospital request must be made to its fiscal intermediary no later than 180 days from the date on the Intermediary's notice of program reimbursement.

Id. (Emphasis added).

The Board concludes that the text of the regulation at 42 C.F.R. § 413.40(e) does not expressly state that a TEFRA exception request must be received by the Intermediary within 180 days from the Notice of Program Reimbursement. Rather, the regulation specifies that "the hospital request must be made to its fiscal intermediary no later than 180 days from the date on the intermediary's notice of program reimbursement." The Board opines that "made" means that a provider must initiate its exception request by mailing or by other delivery method, on or before the 180-day limitation period.

The Board takes notice of the HCFA Administrator's decision in Deaconess Medical Center. In that case, the Administrator, in reversing the Board, stated that "the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation." The Administrator concluded that the agency's interpretation was not inconsistent with the language of the regulation or plainly erroneous. The Board, in applying that

rationale to the instant case, finds and concludes that HCFA's interpretation is inconsistent with the regulation and erroneous based on the following:

The Board notes the ambiguity of the regulation at 42 C.F.R. § 413.40 relative to definition of the term “made”, and the fact that the regulation was amended in 1995 to specifically state that the hospital's request must be received by the intermediary no later than 180 days after the date on the intermediary's initial NPR. At that time, the preamble to the revised regulation states that use of the word “made” has resulted in varying interpretations of the timeliness requirement by hospitals and intermediaries. The Board therefore concludes that if the standard was always "received", as opined by the HCFA Administrator, the original regulation would have so stated, and the 1995 Amendment would then be superfluous.

The Board also reasons that the Provider/Intermediary relationship vis-a-vis the filing through settlement of a Medicare cost report is that of a business relationship. A hospital "making" a TEFRA adjustment request is analogous to an offeree under common law “accepting” a contract offer by placing his or her acceptance of the offer in the mail. The common law “mailbox rule”states that acceptance of a contract offer takes effect upon its dispatch in the mail, even though the offeror may not receive the offer until sometime later. An offeree's placing an acceptance in a mail box forms a contract, unless the offer specifically stipulates that acceptance is not effective until received. The mail box rule is the overwhelmingly dominant rule in the United States. See, Reserve Ins, Co. v. Duckett, 249 Md. 108, 238 A. 2d 536 (Md. 1968), and Morrison v. Thoelke, 155 So. 2d 889 (Fla. Dist. Ct. App. 1963). Applying this principle to the case at hand, it is clear that the governing regulation at 42 C.F.R § 413.40 did not, at the time of the Provider's filing, specify that the application had to be received by the Intermediary within a 180 period. The Board finds that the Black's Law Dictionary definition of the term “filing”, as used by the Intermediary, imposes the judicial meaning of the term “filing” in a legal environment. Here, the Provider was not dealing with a filing deadline to a particular court, but instead was merely conducting a business transaction with its fiscal intermediary. Accordingly, the Board concludes the plain meaning of the term "filing" should prevail.

Based on the above, the Board finds that HCFA's interpretation of the 180-day filing period was not consistent with the specific language of the governing regulation.

DECISION AND ORDER:

The Provider timely filed its TEFRA exception request. The Board remands the case to the Intermediary to review the case on its merits. The Intermediary's determination is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: March 09, 1999

For The Board

Irvin W. Kues
Chairman