PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D12

PROVIDER -
Holladay Park Medical Center
Portland, Oregon

Provider No. 38-0024 & 38-S0024

vs.

INTERMEDIARY -
Blue Cross and Blue Shield
Association/Medicare Northwest

DATE OF HEARING-
August 12, 1999

Cost Reporting Period Ended -
March 31, 1990

CASE NO. 95-0068

INDEX

ISSUE:

1. Was the Intermediary's or HCFA's determination regarding the Provider's TEFRA exception request proper?

JURISDICTION

The Intermediary contends that the PRRB does not have jurisdiction in this case.

FACTS:

On October 9, 1996, The Provider Reimbursement Review Board issued its decision regarding its Jurisdiction over this appeal. The decision reads in part:

> The Board has considered the parties' positions and finds that the Health Care Financing Administration's (HCFA's) Central Office letter of September 26, 1994 affirming the denial of the Provider's adjustment request under 42 C.F.R.§ 413.40 complies with the referenced definition of an "intermediary determination". The Board also finds that the Provider filed its request for a hearing within 180 days of this HCFA determination. The Board, therefore, has jurisdiction over this appeal.

PROVIDER'S CONTENTIONS:

The Provider argues that the decision of the Board constitutes "the law of the case" with regard to the question of PRRB jurisdiction over this appeal. The United States Supreme Court has stated that the law of the case doctrine:

> posits that when a [court or other adjudicative forum] decides upon a rule of law, that decision should continue to govern the same issues in subsequent stages in the same case.... This rule of practice promotes the finality and efficiency of the judicial [or administrative adjudicative] process by "protecting against the agitation of settled issues."

Christianson v. Colt Industries Operating Corp). 486 U.S. 800,816 (1988) (quoting and citing Arizona v. California, 460 U.S. 605,618 (1983) & IB Moore's Federal Practice ¶ 0.404[l] (1984). Under the law of the case doctrine, a court(and by analogy, an adjudicative-administrative entity such as the PRRB) does not "as a general rule reconsider questions" which it has already decided in the same case. Hegler v. Borg.50 F.3d 1472,1475 (9th Cir. 1995).

Although the adjudicative body has discretion as to whether to follow the prior decision in the case, the prior decision should be followed unless "(1) the decision is clearly erroneous and its enforcement would work a manifest injustice, (2) intervening controlling authority makes reconsideration appropriate, or (3) substantially different evidence was adduced at a subsequent trial," Id.

The Provider contends that there is no reason not to apply the presumption that the Board's prior decision, upholding Board jurisdiction over this appeal, should be followed. The only point offered by the Intermediary in its March 19,1999 jurisdictional objection that was not raised in its earlier jurisdictional objections relates to the recent United States Supreme Court decision in Your Home Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999). The decision in Your Home, however, has no bearing on the instant case. The sole issue reviewed and decided by the Court in Your Home was whether the PRRB has jurisdiction to review an intermediary's refusal to reopen a provider's Medicare cost report.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the PRRB does not have jurisdiction to hear the appeal because the Provider did not file a request for an exception to the rate of increase ceiling with the Intermediary. As a result there is no final intermediary decision that is subject to PRRB review. In addition, the Provider did not file an appeal with the PRRB within 180 days of the issuance of the original NPR.

The Intermediary points out that the United States Supreme Court has issued its decision in the case of Your Home in which the Court confronted the question of the PRRB's jurisdiction to review a fiscal intermediary's refusal to reopen a reimbursement determination. In describing the rights of a provider dissatisfied with its intermediary's determination of Medicare reimbursement, the Court stated"... a dissatisfied provider has two ways to get this determination revised. First, a provision of the Medicare Act ... allows a provider to appeal, within 180 days, to the Provider Reimbursement Review Board.... Second, one of the Secretary's regulations ... permits a provider to request the intermediary, within three years, to reopen the reimbursement determination." The Court found that a refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R.§ 405.1885(c) et seq. Your Home Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999).

The Intermediary further contends that the Supreme Court has defined the PRRB's jurisdiction narrowly, and the Provider does not meet the jurisdictional requirements. The Provider did not file an appeal regarding the TEFRA exception request within 180 days of the issuance of the NPR. The Provider did not request a reopening within the three year time period. Therefore, the decision in Your Home upholds the Intermediary's position that the PRRB does not have jurisdiction to hear this case.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Holladay Park Medical Center, ("Provider") operates a distinct part psychiatric unit. In September, 1991 the Provider received a Notice of Program Reimbursement ("NPR") for its 1987, 1988, and

1989 cost reports from Medicare Northwest ("Intermediary"). On March 18, 1992, the Provider submitted a request for adjustment of its TEFRA limit applied to its Distinct Part Psychiatric Unit, The Provider's exception request was submitted within 180 days of the NPRs for the subject years. The applicable statute, 42 U.S.C.§ 1395ww et seq, requires the Secretary "to announce a decision on any request for an exemption, exception, or adjustment....." The applicable regulation, §413.40(e)(2), echoes this requirement. However, HCFA did not comply with the time limits set forth in the statute and regulations. HCFA's decision was issued five months after the expiration of the 180 days during which it was required by law to issue its decision.

The Provider's exception requests for 1987, 1988, and 1989 were based upon permanent changes to its programs and facilities that resulted in correspondingly permanent changes to the underlying cost bases for the psychiatric unit. The Provider experienced significant changes in case mix, an increase in intensity of service, and an increase in average length of stay in the psychiatric unit, all of which were of a permanent nature. These changes resulted from the opening of a new Senior Mental Health Unit, which provided highly individualized treatment to higher acuity patients. As a result of these and other permanent changes to the Provider's programs, the Provider experienced a significant, permanent increase in its psych unit cost base.

On April 5, 1993, HCFA informed the Intermediary of the determination regarding the Provider's exception request for FYE 3/31/89. In that letter HCFA also indicated as follows:

> We are authorizing you as HPH's fiscal intermediary to process subsequent years' requests for adjustments to the TEFRA limitations where HPH has request adjustments based on distortions similar to fiscal year 1989. . . .[1]

The Intermediary informed the Provider of HCFA's determination of the 3/31/89 exception request. On March 24,1993, the Provider made a follow-up of that determination with the Intermediary. The Provider indicated that it would submit the appropriate schedules to receive the adjustments to the TEFRA rates in the 1990 cost reports. The Intermediary never received an actual exception request for FYE 3/31/90 and the related supporting documentation.

The approval of the TEFRA rate was sent by the Intermediary after receiving the favorable TEFRA decision from HCFA. The Provider requested that the Intermediary carry forward the adjustment to later years. The Intermediary responded to the Provider in a letter dated June 2, 1993 as follows:

> In regards to worksheet methodology to calculate amounts for later cost report adjustment requests, the HCFA approval form and methodology is acceptable for future requests. Please note that all

---

[1] Exhibit I-6.

> adjustment requests must be made in writing to the intermediary within 180 days of the Notice of Program Reimbursement (NPR) to which the request is applicable.[2]

The Provider's as-filed FYE 3/31/90 cost report shows on Worksheet D-1 that the Provider's psychiatric unit's costs did not exceed the TEFRA target amount. The finalized cost report, which the Intermediary has settled through the original NPR dated Sept. 16, 1992, shows that the psychiatric unit's costs had exceeded the TEFRA target amount by $588,450.[3] The excess was the result of reducing the psychiatric unit's Medicare discharges from 635 to 422, and correcting the TEFRA target amount per discharge from $4,014.23 to $4,144.98.The Provider did not appeal the Intermediary's determination or submit an exception request to the Intermediary for approval.

The Provider disagreed with the Intermediary's interpretation of HCFA's instruction regarding the review of future exception requests. On March 29, 1994, HCFA informed the Provider:

> ... The fact that a hospital received adjustments in one cost reporting period does not make adjustments in subsequent cost reporting periods automatic. HCFA has granted intermediaries the authority to grant adjustments in subsequent cost reporting periods provided the reasons for the cost distortions are similar to previous requests. Unless a hospital files for an adjustment, neither HCFA nor the intermediary have any basis for making a determination.[4]

Thereafter, the Provider requested HCFA to consider its TEFRA adjustment request for the 1990 cost year. HCFA refused, and the Provider appealed to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.§§ 1835-1841. The Medicare reimbursement is in excess of $10,000.

The Provider was represented by Carol S. Gown, Esq. and David L. Glazer, Esq. of Bennett, Bigelow & Leedom. The Intermediary was represented by Bernard M. Talbert, Esq. of the Blue cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that the Medicare statute did not, and does not, require a provider to submit adjustment requests within 180 days of each year's NPR. 42 U.S.C. §1395ww(b)(4)(A)(i). Instead,

---

[2] Exhibit P-4.

[3] Exhibit I-5.

[4] Exhibit I-9.

the statute is silent on the actual procedure for requesting adjustments, other than requiring the Secretary to announce a decision "not later than 180 days after receiving a completed application from the intermediary." Id.

The regulation addressing the timing of TEFRA exception requests is codified at 42 C.F.R. § 413.40(e) which states in part:

> A hospital may request an exemption from, or exception or adjustment to, the rate of cost increase ceiling imposed under this section. The hospital's 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 intermediary makes a recommendation on the hospital's request to HCFA, which makes the decision. HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the hospital of HCFA's decision. The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for review by the Provider Reimbursement Review Board, as specified in §405.1841 (b) of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

42 C.F.R. 413.40(e).

The Provider points out that the above cited regulation established the Intermediary's notice of program reimbursement as the event triggering the time period during which exception requests must be made. That section does not differentiate between initial NPRs and revised NPRs. Nor does it specifically require that the NPR triggering the timing of an exception request be issued for the year in which the exception is sought, rather than for a prior year that also affects the subject year. Therefore, the regulation can and should be interpreted to include each of these types of intermediary determinations. The Provider argues that the Board should recognize that section 413.40(e) encompassed all of these NPRs, and permitted a provider to await a decision on a prior year's adjustment request before incurring the time and expense of preparing and submitting a similar request for a later year.

The Provider contends that an adjustment request for a particular year must be submitted within 180 days of an NPR which affects that particular year, including a revised NPR reflecting a TEFRA adjustment approved for a prior year. The Board has interpreted section 413.40 in a similar manner in several cases involving exception requests submitted after the issuance of Revised NPRs. Care Unit Hospital of Dallas v. Mutual of Omaha, PRRB dec. No. 95-D26 March 8,1995, Medicare &Medicaid Guide ("CCH") ¶43,222, rev. HCFA Adm. Dec. May 5, 1995 CCH ¶43,510; Foothill Presbyterian Hospital V. Blue Cross of California, PRRB Dec. No. 95-D28, March 8,1995, Medicare and Medicaid Guide CCH ¶43,228, Rev. HCFA Adm. Dec. May 15, 1995 CCH

¶43,538, affirmed, Foothill Presbyterian Hospital v. Shalala, U.S. Dist. Ct. No. CV 95-4674 KN, 1997 WL 67227 (C.D. Cal. Jan 2,1997).

The Provider points out that in each of the above cited cases the Board determined that a provider is entitled to request a TEFRA exception based on a revised NPR, rather than an original NPR, for the subject year. The Board could likewise conclude that an NPR of final determination that reflects TEFRA adjustments approved for a prior year may also serve as the basis for a timely exception request in the subject year.

The Provider argues that HCFA's failure to act on the Provider's prior exception requests for 1987, 1988, and 1989 within the 180 day period set forth in Section 413.40 seriously prejudiced the Provider's ability to submit its request for 1990. Had HCFA issued its decision when it was required to do so by law, the Provider would have had an opportunity to request the continuation of those adjustments for FY 1990 within 180 days of the 1990 NPR.

The Provider contends that it is entitled to a "good cause" exception from the strict application of the 180 day time period, based on HCFA's own recent interpretation of the TEFRA timing requirements. HCFA implicitly recognizes that the timing requirements for providers to submit TEFRA adjustment requests can include a "good cause" exception. In 1995 HCFA published a Final Rule in which it clarified the timing requirements for TEFRA exception requests submitted pursuant to 42 C.F.R.§ 413.40. See 60 Fed Reg. 45778(Sept. 1, 1995) (“the 1995 rule”). The 1995 rule stated:

> While section 1886(b)(4)(A) of the Act, which provides the Secretary with the authority to grant exceptions to the per discharge limit, does not specify requirements with regard to timely filing of an exception request, we believe it is appropriate to examine section 1878 of the Act. That section addresses timely filing of a hearing request with the Provider Reimbursement Review Board (PRRB). Such a request, like an exception request, involves a provider seeking reimbursement in addition to that set forth in its notice of program reimbursement. For that reason, we believe that our policy with regard to the timely filing of an exception request should be consistent with section 1878 of the Act.

60 Fed Reg. at 45841.

The Statute cited above in HCFA's 1995 rule, Section 1878 of the Social Security Act generally gives providers the right to appeal a final determination to the PRRB within 180 days. 42 U.S.C.§ 1395oo(a). HCFA's own regulations interpreting and implementing the statute, however, provide for an extension of the 180 day period for "good cause." 42 C.F.R. §405.1841 (b). Under this provision an appeal may be filed up to three years after the date of the challenged final determination, where "good cause" is shown.

The Provider points out that the Board has discretion to grant a good cause exception based on the 1995 Rule interpreting the timing requirements for TEFRA exception requests. In addition, HCFA's own regulations may support the application of the good cause exception in cases such as this one. Section 413.40, which addressed the timeliness of TEFRA exception requests, provides that the period during which HCFA was reviewing an exception request constituted"good cause" for an extension of the 180 day time period discussed in 42 C.F.R.§ 405.1841 et seq. The regulation states:

> The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for review by the Provider Reimbursement Review Board, as specified in §405.1841 (b) of this chapter. 42 C.F.R. §413.40(c)(1990).

Although this provision expressly applies to extensions of time in which to file PRRB appeals, HCFA's 1995 statement concerning "consistent" application of TEFRA adjustment requests and PRRB appeals makes the application of this provision equally appropriate in this instance. If the period during which HCFA review is pending constitutes good cause to grant an extension of time for filing a PRRB appeal, it should also be grounds for extending the time in which a provider can submit a TEFRA exception request.

The Provider contends that under the circumstances, where HCFA substantially delays its issuance of decisions concerning a provider's prior TEFRA requests, thereby impacting the timeliness of the instant [1990] request, the time required for HCFA to review the request (42 C.F.R. 413.40(e)) mandates a good cause exception to the rigid application of the 180 day period.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that since the Provider did not file a request for an exception to the rate of increase with the Intermediary, there is no intermediary or HCFA decision that is subject to the PRRB's review, pursuant to 42 C.F.R.§ 413.40(e). The Intermediary further argues that HCFA's letters to the Provider only contain clarifications and affirmations of the Intermediary's findings regarding the TEFRA exception filing and appeal requirements under the related program policies. These letters do not constitute an intermediary or HCFA determination of a TEFRA exception request in the context of those program policies.

The Intermediary also points out that HCFA authorized the Intermediary to make a final determination or decision on future exception requests, including the FYE 3/31/90 request. The Provider should have requested the PRRB's review of the Intermediary's determination. Therefore, the PRRB should find that the Provider's appeal on October 19, 1994 was not timely.

The Intermediary argues that the Provider has no basis for appeal. HCFA's approval of the Providers TEFRA exception request for FYE 3/31/89 does not extend to FYE 3/31/90. The process regarding TEFRA exception request review in the referenced program policies applies on a per case or cost

report basis. Under the circumstances, there is no FYE 3/31/90 exception request that identifies the costs that are subject to exception and specifies the circumstances on which these costs are attributable. The fact that a hospital received adjustments in one cost reporting period does not make adjustments in subsequent cost reporting periods automatic.

The Intermediary points out that both the 1990 and 1991 editions of the Code of Federal Register do not contain any provisions that prohibit the Provider from filing the FYE 3/31/90 exception request or appealing the original NPR while its FYE 3/31/89 exception request is pending HCFA's determination. Both editions clearly state that the Provider must file a request no later than 180 days from the date of the NPR. Since the Provider did not file a TEFRA exception request, there was no delay involved in an approval process. Therefore, the Provider does not have "good cause" for pursuing a late appeal of the Intermediary's NPR.

The Intermediary argues that the Provider should have filed an appeal within 180 days from the date of the original NPR. That NPR contains the Intermediary's original determination regarding the psychiatric unit's TEFRA target amount. That determination resulted in the disallowing the psychiatric unit's reasonable allowable costs that exceeded the TEFRA target amount.

The Intermediary points out that the Provider's appeal was within 180 days of the revised NPR. However, the revised NPR was not about the Intermediary's determination of the psychiatric units target amount or exception request. The revised NPR did not result in revising the settlement of the psychiatric unit's costs. The revision merely increased the costs that exceeded the TEFRA target amount as determined through the original NPR. Also, the Provider appealed what it considered HCFA's final determination, not the revised NPR. The Intermediary argues that the Provider can appeal a revised NPR only to the extent of the adjusted items in the revised NPR. A revised NPR does not open the entire cost report to appeal or extend the 180-day appeal period for any earlier NPR.

The Intermediary contends that the Provider could have pursued the matter through the reopening process, but did not do so. At this time the 3-year period for implementing any cost report reopening has already expired. Also, even if the Provider had requested a cost report reopening, the Intermediary would have denied the request because the Provider did not file an actual and acceptable exception request. The PRRB would not have the authority to decide in that regard, pursuant to 42 C.F.R. §405.1885 which states "...(c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision..... Furthermore, the Provider could not appeal that determination, pursuant to HCFA Pub. 15-1 § 2932.1 which states: "A provider has no right to hearing on a finding by an intermediary or hearing officer that a reopening or correction of a determination or decision is not warranted...." Id.

The Intermediary contends that the Provider did not have a good cause for filing an untimely exception request, appeal request, or reopening request. Although not defined in program regulations and instructions, good cause is synonymous to good reason or justifiable purpose in seeking an extension.

A good cause is one that shows a substantial reason and affords a legal excuse for delay, or an intervening action beyond the Provider's control. The Provider did not have valid reasons for not complying with the established filing requirements because the program laws, regulations and instructions that clearly describe these requirements are publicly available and accessible to providers.

The Intermediary argues that it did not abuse its discretion or make an arbitrary determination. Black's Law Dictionary defines abuse as a "departure from reasonable use" and abuse of discretion as "being synonymous with a failure to exercise a sound, reasonable, and a legal discretion." Consistent with those definitions, the Intermediary and HCFA maintain that they did not make an erroneous conclusion or judgement that is against logic. They made a determination upon consideration of the underlying facts and the related program policies.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§1878	-	Provider Reimbursement Review Board

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

§1395ww et seq.	-	Payments to Hospitals For Outpatient Hospital Services
§1395oo(a)	-	Provider Reimbursement Review Board

3. Regulation 42 C.F.R.:

§413.40 et seq.	-	Ceiling on Rate of Hospital Cost Increases
§§405.1835-1841 et seq.	-	Right to Board Hearing
§405.1885 et seq.	-	Reopening a Determination or Decision
§405.1841(b)	-	Time, Place, Form, and, Content of Request for Board Hearing

4. Program Instructions- Provider Reimbursement Manual Part I (HCFA Pub. 15-1):

§2932.1	-	Notice of Refusal to Reopen or Correct

5. Cases:

Christianson v. Colt Industries Operating Corp. 486 U.S. 800 816 (1988) (quoting and citing Arizona v. California, 460 U.S. 605, 618 (1983) 1B Moor's Federal Practice §0.404[1] (1984).

Hegler v. Borg. 50 F.3d 1472, 1475 (9th Cir. 1995).

Your Home Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999).

Care Unit Hospital of Dallas v. Mutual of Omaha, PRRB Dec. No. 95-D26, March 8, 1995, Medicare and Medicaid Guide ("CCH") ¶43,222, rev. HCFA Adm. Dec. May 5, 1995 CCH ¶43,510.

Foothill Presbyterian Hospital v. Blue Cross of California, PRRB Dec. No. 95-D28, March 8, 1995, Medicare and Medicaid Guide ("CCH") ¶43,228, Rev. HCFA Adm. Dec. May 15, 1995 CCH ¶43,538, affirmed, Foothill Presbyterian Hospital v. Shalala, U.S. Dist. Ct. No. CV 95-4674KN, 1997 WL 67227 (C.D. Cal. Jan 2, 1997).

6. Other

Black Law Dictionary

60 Fed. Reg. ¶45,778

60 Fed. Reg. ¶45841

PRRB Jurisdiction Decision - October 9, 1996

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after consideration of the parties' contentions, and evidence presented finds and concludes that it does not have jurisdiction and therefore the issue presented by the Provider is moot.

The Board, in reviewing its prior decision of October 9, 1996 erroneously concluded, based on the Intermediary letter of April 7, 1994 and the HCFA letter September 26, 1994 that there was an Intermediary determination, and that the Provider appealed that determination within the 180 day time limit. Upon further review, the Board finds that the letter from HCFA dated September 26, 1994 was not a final determination but a clarification of HCFA policy. That prior decision erroneously stated in part:

> The board ... finds that the Health Care Financing Administration's (HCFA) Central Office letter of September 26, 1994 affirming the denial of the Provider's adjustment request under 42 C.F.R. §413.40 complies with the referenced definition of an "intermediary determination." The Board also finds that the Provider filed its request for a hearing within 180 days of this HCFA determination.

Id.

The Board also finds that the Provider argued that it intended to file its exception request after it received approval of the prior years exception requests. However, the Provider never filed its exception request. The Board notes that HCFA took an inordinate amount of time to respond to the Provider's request for an exception to the 1987, 1988 and 1989 cost report limit. However, this did not relieve the Provider of its responsibility of filing a timely exception request within 180 days as mandated by the HCFA regulations. The Board finds that this is not "good cause" to relieve the Provider from its responsibility to file within 180 days.

DECISION AND ORDER:

The Board does not have jurisdiction of this case. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

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

Date of Decision: December 14, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman