PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D44

PROVIDER –
Maine Medical Center

Provider No. 20-0009

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/Associated Hospital Service of Maine

DATE OF HEARING -
September 24, 2001

Cost Reporting Periods Ended
September 30, 1992

CASE NO. 97-3201

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ISSUE:

Was it proper for the Intermediary to deny the Provider's TEFRA exception request for untimely filing?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maine Medical Center ("Provider") is a voluntary not-for-profit general short term teaching hospital located in Portland, Maine. The Provider is licensed to operate a 640 bed acute care facility and also operates a 26 bed distinct part psychiatric unit which is reimbursed under the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA").

The Intermediary issued a Notice of Program Reimbursement ("NPR") for the Provider's fiscal year 1992 Medicare cost report on September 25, 1995.[1] On March 20, 1996, the Provider submitted a letter to the Intermediary requesting an adjustment to the rate of increase ceiling on hospital inpatient costs imposed under the TEFRA exception for its psychiatric unit.[2] On April 3, 1996, the Intermediary returned the Provider's request advising that it was incomplete.[3] On September 9, 1996, the Provider filed an appeal with the Provider Reimbursement Review Board ("Board") and the Board assigned case number 96-2571 to the Provider's appeal.[4] That appeal was subsequently withdrawn by the Provider on August 18, 1997.[5]

The instant appeal was filed on September 17, 1997[6] and stems from the Intermediary's March 20, 1997 denial[7] of the Provider's January 21, 1997 exception request.[8] The Intermediary raised a jurisdictional objection stating that the Provider was filing a second appeal beyond 180 days from the issuance of the NPR. The Board found that the Intermediary's March 20, 1997 letter was a distinct, appealable notice and as such, the Provider has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.[9] Consequently, the Board agreed to hear the appeal of the Intermediary's March 20, 1997 determination that the Provider's TEFRA exception request was not timely. The estimated impact on Medicare reimbursement is approximately $468,000.

The Provider was represented by Mr. William H. Stiles, Esquire, of Verrill & Dana, LLP. The Intermediary was represented by Ms. Elaine Bradley, Esquire, of the Blue Cross and Blue Shield Association.

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1 Provider Exhibit P-1.
2 Provider Exhibit P-2
3 Provider Exhibit P-5
4 Provider Exhibit P-7
5 Provider Exhibit P-17
6 Intermediary Exhibit I-14
7 Provider Exhibit P-14
8 Provider Exhibit P-13
9 See Board letter dated May 3, 2001.

PROVIDER'S CONTENTIONS:

The Provider contends that it made a single timely TEFRA exception request on March 20, 1996.[10] However, the Intermediary returned the exception request as incomplete, and did not set a deadline for filing supplemental documentation to "complete" the application.[11] The Provider completed the application on January 21, 1997, as it was entitled to do under the applicable regulations and manual instructions.[12]

The Provider also contends that the Intermediary cannot simply ignore a TEFRA request that contains some, but not all, of the criteria set forth in CMS Pub. 15-1 § 3004.2. CMS Pub. 15-1 § 3004.3 requires that the Intermediary review the exception request for completeness and request any missing information, setting a reasonable deadline if it so desired. If the Provider fails to supply the requested additional information, the Intermediary is required to process the request based upon the information already received and make a final decision on the merits (or a recommendation to CMS).

The Provider further contends that in order for the Intermediary to prevail, the Board must make one of the following four findings. First, the Board must find that the Provider's March 20, 1996 letter is not a "request" under the applicable law. Second, if the request is deemed proper, the Board must find that the Intermediary's April 3, 1996 letter properly denied the request under the applicable law. Third, in the absence of a denial, the Board must find that the Provider cannot supplement its request after the expiration of 180 days from the NPR. Finally, the Board must find that the Provider did not exercise its right to supplement its request in a timely fashion. Absent these findings, the Provider contends it must prevail. As explained more fully below, not one of these findings is supported by the applicable law or the record in this case.

1. The Provider's March 20, 1996 letter was a request pursuant to the applicable law.

It is important to note that neither the statute nor the regulation governing TEFRA exceptions specifies the required contents of a request. Thus, the Board should measure the Provider's March 20, 1996 letter against the normal and accepted usage of the word. Webster's New World Dictionary defines the word request as "an asking for, or expressing a desire for, something; solicitation or petition." The Provider contends its letter easily satisfies that definition. It plainly requests an exception to its rate-of-increase ceiling, identifies the amount, the regulatory basis and the reason for the request.[13]

The Provider asserts that the plain language of the law provides additional support for the Provider's position. For example, the statute at 42 U.S.C. § 1395ww(b)(4)(A)(i) makes a

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10 Provider Exhibit P-2
11 Provider Exhibit P-5
12 Provider Exhibit P-13
13 Provider Exhibit P-2.

clear distinction between a "request" and "completed application."[14] It proves that Congress intended that there be a difference between the original request and the final, completed application. Significantly, the Secretary adopted this distinction in the TEFRA regulation at 42 C.F.R. § 413.40(e)(4).

The Provider also contends that the Intermediary's testimony at the hearing served to discredit the Intermediary position. First, the Intermediary witness testified that if a provider does not submit all of the documentation or information listed in CMS Pub. 15-1 § 3004.2, it is not a bona fide request, and the Intermediary is foreclosed from taking any action on it (including a request for the missing information).[15] Subsequently, the same witness conceded that a request that is missing some of the information set forth in § 3004.2 is still considered a request.[16] Additionally, he also conceded that the plain language of § 3004.3 requires the Intermediary to request all necessary additional information when the Intermediary has deemed the request incomplete.[17]

Thus, reading the statutes, regulations and manual as a whole, and in light of the Intermediary's own concession, the Provider contends its March 20, 1996 letter met the requirements of a "request."

2. The Intermediary's April 3, 1996 letter was not a de facto denial of the Provider's request.

The Provider is not in agreement with the Intermediary's argument that the April 3, 1996 letter was a de facto denial, and that the Provider erred by dropping its original appeal of that letter. First, the word "denial" does not appear anywhere within the letter. The Intermediary merely states that the request is incomplete, and it is being "returned." Since CMS Pub. 15-1 § 3004.3 requires the Intermediary to review an application for completeness and request "any necessary additional information," the Intermediary's actions can only be interpreted as a request for the information set forth in § 3004.2.

Second, the same manual instruction states that an intermediary's decision letter must include "a detailed explanation of the grounds for approval or disapproval of the adjustment request." The April 3, 1996 letter failed to use the word "denial," much less set forth a "detailed explanation." Accordingly, it cannot have the effect of a de facto denial.

Third, the Provider contends that the Intermediary's characterization of its letter has changed over the course of this proceeding. Initially, the Intermediary argued that it did not make a determination on the request, but "simply returned" it without making a decision.[18] Now, the Intermediary argues that it was a denial.

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14 Provider Exhibit P-3.
15 Tr. at 243-244.
16 Tr. at 244-245.
17 Tr. at 261.
18 Provider Exhibit P-11.

Fourth, the Intermediary did not have the option under statute, regulation or the manual of denying the March 20, 1996 letter as "incomplete." CMS Pub. 15-1 § 3004.3 requires the Intermediary to review the application for completeness and request "any necessary additional information." It even had the option of setting a reasonable deadline for the submission of additional information. If the Provider failed to supply the requested information within the specified deadline, the Intermediary was required to go forward with the request and make a decision based upon what was available. Admittedly, the Intermediary did not make a decision on the merits based upon what was submitted. Instead, it returned the application without making any decision.[19]

Based on the above, the Provider contends that the first and only time the Intermediary denied the Provider's Request was March 20, 1997.

3. The Provider may supplement its TEFRA request after the 180 day period.

The Provider contends that the language of the applicable statute at 42 U.S.C. § 1395ww(b)(4)(A)(i) and the regulation at 42 C.F.R. § 413.40(e)(3) clearly contemplates supplemental documentation.[20] For example, both provisions draw a distinction between a "request" and a "completed application." Moreover, § 413.40(e)(4) permits the Provider to request a reconsideration and supply additional information after the Intermediary (or CMS) issues its final decision.[21] Again, if additional documentation may be submitted after the final decision, the Provider contends it is entitled to submit it before one is made.

Second, if CMS intended to foreclose supplemental documentation after the original 180 day period, it would have done so. Indeed, CMS implemented such a limitation when creating the End Stage Renal Disease exception process set forth at 42 C.F.R. § 413.170.[22] This provision does not allow additional information past the 180 day period, in contrast to 42 C.F.R. § 413.40 and CMS Pub. 15-1 § 3004.3, which clearly contemplate it.

Third, as stated above, even the manual provision upon which the Intermediary relies contemplates supplemental documentation following the 180 day period. Again, within 60 days after the receipt of the request, the Intermediary is required by CMS Pub. 15-1 § 3004.3 to review it for completeness and request any additional information. The manual instruction contains no deadline for the filing of additional information but permits the Intermediary to set a reasonable one if it so desires.

This section also refers to "the date of the request" as "the date of the first letter from the

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19 Tr. at 254, 236-257.

20 Provider Exhibits P-3 and P-27, respectively.

21 The 180 day deadline for reconsideration and supplemental documentation begins when the Provider receives the Intermediary's (or CMS's) decision under 42 C.F.R. § 413.40(e)(ii) or (iii).

22 Provider Exhibit P-28.

hospital," not the date the application is complete. Thus, the manual section upon which the Intermediary relied in "returning" the Provider's adjustment request not only contemplates supplemental documentation, but requires it.

4. The Provider properly supplemented its TEFRA request in a timely basis.

The Provider contends that it supplemented its request in accordance with all applicable regulations and manual provisions. First, neither the regulation nor manual contain a deadline for supplying additional documentation. Rather, the manual gives the Intermediary the discretion to set a reasonable deadline. In this case, however, the Intermediary did not set a deadline for filing the supplemental information when returning the Provider's request. Nor did it send followup correspondence advising the Provider that it was taking too long. Most importantly, it did not process the request as required by CMS Pub. 15-1 § 3004.3.

Second, the Intermediary's and CMS's own practices support the timeliness of the Provider's supplemental documentation. CMS has argued that a 3-and-3/4 year delay between the Notice of Reopening and the Notice of Correction was not unreasonable, even though the reopening window itself was limited to three years. See Stanislaus Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 98-D70, July 2, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,021, dec'l. rev., HCFA Administrator, August 24, 1998.[23] Also, the Board recently upheld the Intermediary's eight year delay between a notice of reopening and the finalization of that reopening, reasoning that the three year reopening limitation applied to the start of the process only, and that there is no limitation on the issuance of a revised NPR once the process has begun. See Leo N. Levi Memorial Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2001D-51, September 26, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,742, dec'l. rev., HCFA Administrator, November 14, 2001. Similarly, the Provider started the TEFRA adjustment process on a timely basis, and there is no statutory, regulatory or manual deadline for submitting supplemental documentation in order to complete an application (in the absence of the Intermediary setting one, which it did not do in this case). Since the CMS Administrator has suggested that a reasonable guideline for determining timeliness in the absence of a specified deadline is the three year reopening period itself, it is clear that the Provider's submission was timely. See University of California Medical Center v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of California, PRRB Dec. No. 96-D71, September 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,703, rev'd, HCFA Administrator, November 29, 1996, Medicare & Medicaid Guide (CCH) ¶ 45,031.

Finally, the Provider points to the case of Hurley Medical Center v. Shalala,Case No. 98-CV-60388 (E.D. MI February 17, 2000), wherein the court stated that based on the regulations and case law, there was no specific requirement that the contents of a TEFRA adjustment request had to be submitted within 180 days of the NPR.[24]

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[23] Provider's Post Hearing Brief at P-29.

[24] Provider's Post-Hearing Brief at P-30.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the Provider submitted a letter requesting a TEFRA exception on March 20, 1996.[25] That letter was reviewed by the Intermediary and a determination was made that it did not constitute a proper request since the information required in CMS Pub. 15-1 § 3004.2 was not included. The Intermediary returned the letter to the Provider on April 3, 1996.[26] The Intermediary contends it acted properly in returning the letter, without making a determination, since the letter did not meet the requirements of CMS Pub. 15-1 § 3004.2.

Section 3004.2 outlines in detail the information required for a hospital's adjustment request, which must include the following information:

- Name, address and provider number of the requesting facility;
- General information about the hospital (e.g., type of facility, description of the patient population, area served);
- Type of relief requested and regulatory basis; (i.e., adjustment to target amount under 42 C.F.R. § 413.40(g));
- Identification of the source(s) of the higher costs (e.g., higher costs due to additional patient services or to an increase in the average length of stay);
- A demonstration that the higher costs are:
  - Above the target amount;
  - Reasonable and justified;
  - Related to direct patient care services; and,
  - Attributable to the circumstances specified;
- Specification and documentation of the factors contributing to the higher costs compared to the base year;
- Documentation and quantification of the direct effect of the contributing factors on Medicare operating costs; and,
- An explanation of other significant cost increases since the base period.

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25 Intermediary Exhibit I-1.

26 Intermediary Exhibit I-2.

The Provider's letter does not include all the above-required information. In fact, the Provider merely wrote a letter to the Intermediary which indicated that there was a disparity between the actual cost of the TEFRA unit and Medicare reimbursement, and provided absolutely no documentation to support its position even though the instructions referenced in its letter required this information. Upon examination of the Provider's March 20, 1996 letter, it is clear that the Provider only met the first and third bullet of the Manual instructions cited above.

The Intermediary further points out that on March 7, 1996, the CMS Boston Regional Office issued a reminder to fiscal intermediaries of their authority when making determinations in accordance with CMS Pub. 15-1 § 3004.3.[27] CMS not only grants the intermediaries the authority to deny a request, but also gives intermediaries the authority to return to providers those requests which are not in the format, or do not contain the information, required by CMS Pub. 15-1, § 3004.2.

The Intermediary contends its position is further supported by the HCFA Administrator's reversal of the Board's decision in the University of California Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Dec. No. 96-D71, September 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 45,703, rev'd, HCFA Administrator, November 29, 1996, Medicare & Medicaid Guide (CCH) ¶ 45,031 ("University of California"). In that decision, the CMS Administrator found it was proper and within HCFA's discretion to deny any revised requests which were submitted after an unreasonable amount of time had passed.

The Intermediary also notes that in a letter dated January 21, 1997, the Provider again requested a TEFRA exception for the cost reporting period ending 9/30/92.[28] This request was 480 days after the NPR, and more than 10 months after the original letter was returned to the Provider as incomplete. It was also 300 days beyond the regulatory time frame of 180 days.

Accordingly, the Intermediary contends that if the Board were to determine that the Provider's letter of March 20, 1996, did constitute a proper request (which the Intermediary argues), and that the submission of the letter of January 21, 1997, was a revised request (which the intermediary also argues), then certainly more than 10 months after the initial request would constitute an unreasonable amount of time. Thus, the Intermediary properly denied the Provider's additional request in a letter dated March 20, 1997,[29] per the rationale in the Administrator's decision in the University of California case.

In summary, the Intermediary contends that the Provider apparently wants a "second bite of the apple" by attempting to file an appeal from the Intermediary's letter dated March 20, 1997 while ignoring the Intermediary's denial dated April 3, 1996. This is improper,

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27 Intermediary Exhibit I-7.
28 Intermediary Exhibit I-9.
29 Intermediary Exhibit I-10.

as the Intermediary made a final determination on April 3, 1996, and the Provider's first request for a hearing, dated September 6, 1996, was from the Intermediary's April 3, 1996 denial letter. The Intermediary's letter dated March 20, 1997, can only be construed as an affirmation of its prior April 3, 1996 denial and nothing more. The Provider should not be allowed to reintroduce the TEFRA Target Rate issue for fiscal year ending 9/30/92 a second time.[30]

Finally, the Intermediary asserts that even if the Board accepts the Provider's argument that its request for a TEFRA Target Rate dated March 20, 1997 qualifies as a bona fide request (which the Intermediary argues), the Board must deny the Provider's request for a hearing as untimely. The regulation at 42 C.F.R. § 405.1841 requires that a provider must file its request for a hearing, in writing, to the Board within 180 days of the date the determination was mailed to the provider. The Provider's second request for a Board hearing, dated September 17, 1997, was untimely as it was filed 181 days from the Intermediary's affirmation of its original determination.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law 42 U.S.C.:

§ 1395ww(b) et seq.	-	Rate of increase in target amounts for inpatient hospital services

2. Regulations – 42 C.F.R.:

§ 405.1835-.1841	-	Board jurisdiction
§ 413.40	-	Ceiling on the rate of increase in hospital inpatient costs
§ 413.40(e)(3)	-	Intermediary decision
§ 413.40(e)(4)	-	Notification and review
§ 413.170	-	Scope

3. Program Instructions – Provider Reimbursement Manual Part I (CMS Pub. 15-1):

§ 3004.2	-	Requesting adjustment

[30] The Provider had filed a prior appeal from the Intermediary's letter dated April 3,1996. In lieu of responding to a request for a jurisdictional brief the Provider withdrew its initial appeal, and filed another appeal based on the Intermediary's March 20, 1997 letter.

§ 3004.3 - Intermediary role

3. Cases:

Stanislaus Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 98-D70, July 2, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,021, dec'l. rev. HCFA Admin., August 24, 1998.

Leo N. Levi Memorial Hospital v. Blue Cross and Blue Shield Association, PPRB Dec. No. 2001D-51, September 26, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,742, dec'l. rev., HCFA Admin., November 14, 2001.

University of California Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Dec. No. 96-D71, September 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 45,703, rev'd, HCFA Admin., November 29, 1996, Medicare & Medicaid Guide (CCH) ¶ 45,031.

Hurley Medical Center v. Shalala, Case No. 98-CV-60388, (E.D. MI. February 17, 2000), Medicare & Medicaid Guide (CCH) 2000-1 ¶ 300,417.

4. Other

Tax Equity and Fiscal Responsibility Act of 1982.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that on March 20, 1996, the Provider wrote to the Intermediary requesting a TEFRA rate adjustment. On April 3, 1996, the Intermediary returned the Provider's letter stating that the Provider failed to meet the requirement of CMS Pub. 15-1 § 3004.2. As a result, the Provider filed a request for a Board hearing on September 9, 1996. On January 21, 1997, the Provider filed what the Intermediary has characterized as a second request for a TEFRA rate adjustment, and what the Provider characterizes as a completed application. The Intermediary denied (on March 20, 1997) the Provider's second submission for a TEFRA rate adjustment as being untimely. On August 18, 1997, the Provider withdrew its original request for a Board hearing and filed its September 17, 1997 request for a Board hearing on the January 21, 1997 submission.

The regulation at 42 C.F. R. § 413.40(e)(3) states that the Intermediary is to issue a decision no later than 180 days after receipt of the completed application. Additionally, CMS Pub. 15-1 § 3004.3 states that:

> [w]hen the Intermediary receives an application for relief from the rate of increase ceiling, the intermediary reviews the application for completeness and requests any necessary additional information within 60 days. In its request for additional information, the intermediary may establish a reasonable deadline for the hospital's response. If the hospital has not responded with the requested

> information by the deadline, the intermediary either forwards the application and its recommendation to HCFA, or (if authorized) makes a final determination on the basis of the information it has received. The Intermediary evaluates the hospital's request and verifies the supporting documentation.

The Board finds that the Intermediary's April 3, 1996 letter merely returned the Provider's request without using the term "denied" or offering any additional guidance or advice. The Board further finds that the Intermediary does not have the option to return the Provider's request without approving or denying it. The manual cited above clearly contemplates the submission of incomplete requests and specifies procedures for dealing with those circumstances. Accordingly, the Board finds that the Intermediary's April 3, 1996 letter does not constitute a final determination.

The Board further finds, in the instant case, that the Provider's application process is a continuum to its eventual completion. In that regard, the Board notes that the Provider eventually completed its request on January 21, 1997. The Board views that submission as a bona fide request.

With regard to the Intermediary's timeliness argument, the Board finds that the regulation at 42 C.F.R. § 405.1841(a) states that:

> [t]he request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider . . .

The Board notes that in the case at hand there is no valid evidence in the record to indicate that the Intermediary's March 21, 1997 denial letter was actually mailed on that date. Nor was there any evidence in the record to indicate that the Provider actually received the Intermediary letter on the same date that the letter was dated (March 21, 1997). Accordingly, the Intermediary argument that the Provider's request for a Board hearing was filed one day late is without merit.

DECISION AND ORDER:

The Intermediary's determination that the Provider's TEFRA exception request was untimely was not proper. The Board concludes that the TEFRA exception request was timely filed and hereby remands this case to the Intermediary for consideration of the Provider's request on its merits.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire
Date of Decision: September 26, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman