PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D37

PROVIDER – New Hanover Regional Medical Center & Psychiatric Unit
Wilmington, North Carolina

Provider No. 34-0141 &
34-S141

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina

DATE OF HEARING –
March 11, 2003

Cost Reporting Period Ended
September 30, 1991

CASE NO. 94-2728

INDEX

ISSUE:

Whether the Intermediary and HCFA[1] properly determined that the Provider's request for an adjustment to the TEFRA target limits was untimely.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Tax Equity and Responsibility Act of 1982, 42 U.S.C. § 1395ww(b) (TEFRA), established target limit costs which applied to all hospitals. HCFA issued regulations at 42 C.F.R. § 413.40 to implement the TEFRA requirements. Part of these regulations, 42 C.F.R. § 413.40(e)(i), establishes certain time requirements for providers to submit requests for adjustments to the rate-of-increase ceiling imposed under this section to the provider's fiscal intermediary. This case concerns the timeliness of the Provider's submission.

Section 1866(d) and (g) of the Social Security Act established Medicare's Prospective Payment System (PPS) for the inpatient services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983. This law was implemented by HCFA via Part 412 of the Medicare Regulations. Subpart A of Part 412 provides the general provisions of PPS. Subpart B provides provisions for hospital services which are subject to and excluded from PPS for inpatient operating costs. Specifically, 42 C.F.R. §§ 412.22-412.27 deal with issues relating to the requirements for excluded psychiatric units such as the Provider's.

The New Hanover Regional Medical Center (Provider) has a 40-bed, distinct-part PPS exempt psychiatric unit. This psychiatric unit exceeded its TEFRA target limit beginning in 1988. Its average length of stay (ALOS) had increased substantially over the ALOS in its TEFRA base year. The unit also had to add additional staffing.[2] For fiscal year ended September 30, 1988, (FY 88) HCFA granted the Provider's request for an adjustment to the TEFRA target limit. Because the Provider's operations had undergone a permanent change, it was foreseeable that annual adjustments would have to be made to accommodate these changes. HCFA, therefore, delegated its authority to Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina (Intermediary) to approve similar requests for adjustments using the same methodologies as those used for FY 88. Pursuant to its delegated authority, the Intermediary approved the Provider's request for adjustments to the TEFRA target limits for fiscal years ended September 30, 1989 and September 30, 1990.[3]

The Provider's Notice of Program Reimbursement (NPR) for fiscal year ended September 30, 1991 (FY 91), the year at issue in this case, is dated September 30, 1993.[4] The Provider did not receive its NPR until October 5, 1993.[5] By letter dated March 31, 1994, the Provider requested

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[1] HCFA is now the Centers for Medicare and Medicaid Services (CMS).
[2] See Provider Exhibit P-1.
[3] See Provider Exhibit P-2
[4] See Provider Exhibit P-3.
[5] See Provider Exhibits P-3 and P-4.

an adjustment to the TEFRA limits for FY 91.[6] By letter dated May 5, 1994, the Intermediary notified the Provider that its March 31, 1994 adjustment request was denied because it had not been timely filed.[7] The Provider's costs exceeded the TEFRA target limits by $497,672 for FY 91.

The Provider appealed the Intermediary's determination of late filing under 42 C.F.R. § 413.40 to the Provider Reimbursement Review Board (Board). The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider is represented by Carel T. Hedlund, Esquire, of Ober, Kaler, Grimes and Shriver. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that pursuant to 42 C.F.R. § 413.40(e)(1), it made a timely request to review its exception request. Although the regulation suggests that a 180 day period within which a provider is required to make an adjustment request begins from the date of the NPR, HCFA has constantly construed and applied it to mean the date of receipt of the NPR by a provider. By allowing 7 days for mailing, the Provider would have had to make its adjustment request by April 4, 1994.

The Provider contends that the regulation presumes that the TEFRA request filing date is based on the premise that the NPR is mailed to the provider on the date it was dated. If the date on the NPR is different from the date of mailing, then the mailing date controls, and the 180 day limit begins from the mailing date. If the date of mailing is unknown, then the date receipt of the NPR by the provider will trigger the running of the 180 day period.

The Provider notes that in an analogous context, the regulation governing appeals to the Board, 42 C.F.R. § 405.1841(a)(1), requires a provider to make a request for a Board hearing within 180 days of the date the notice of the intermediary's determination was mailed to a provider. Significantly, however, this regulation has been consistently construed and applied by both HCFA and the Board to mean that the date of a provider's receipt of the NPR, actual or constructive, triggers the running of the 180-day appeal period. The Provider Reimbursement Manual, HCFA Pub. 15-1, § 2920.A.2 provides that the hearing request must be filed with the Board no later than the 180th calendar day following the date of receipt by the provider of the final determination.

The Provider observes that the Board has consistently followed the policy prescribed by the Provider Reimbursement Manual. In Forest City Nursing Home v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Western Pennsylvania, PRRB Hearing Dec. No. 95-D50, Aug. 18, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,595, the Board upheld the timeliness of an appeal filed 181 days after the date of the NPR. The HCFA Administrator acquiesced to the Board's determination. Applying these rules to the particular facts involved in

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[6] See Provider Exhibit P-5.
[7] See Provider Exhibit P-6.

this appeal, the Provider's adjustment request was timely made. The Provider actually received the NPR on October 5, 1993. Furthermore, using the five-day rule for constructive receipt of the NPR, the Provider would be deemed to have received an NPR dated September 30, 1993 on October 5, 1993. Thus, under either rule, the Provider would have been required to make its adjustment request by April 3, 1994. The Provider's adjustment request, which made on March 31, 1994, is therefore timely.

The Provider contends that the Board should interpret the regulation in a manner that promotes justice. There is no statutory basis for the 180-day deadline for making an adjustment request. The deadline is merely a "procedural rule" to promote the "ends of justice." In American Farm Lines v. Black Ball Freight Service, 397 U.S. 532, 539 (1970), the Supreme Court held that "[i]t is always within the discretion of a court or an administrative agency to relax or modify its procedural rules adopted for the orderly transaction of business before it when in a given case the ends of justice require it." Id.

The Provider contends the Board should interpret the TEFRA regulation in the same way that the Board appeal regulation has been interpreted. A strict application of HCFA's and the Intermediary's construction of the timeless standard for a TEFRA adjustment request in this case would defeat "the ends of justice." Further, the Board should apply the doctrine of "equitable tolling." The Supreme Court has repeatedly approved the application of the "equitable tolling" doctrine to statutes of limitation to prevent unjust results.

The Provider contends that its failure to make its adjustment request within 180 days of the date of the NPR constitutes excusable neglect because the following circumstances are sufficiently misleading to cause a reasonable person to believe that the adjustment request had to be made only after receipt, actual or constructive, of the NPR. The attachment to the Provider's FY 91 NPR advising it of its right to appeal to the Board states that the appeal must be filed within 180 days of the date of the NPR. The TEFRA regulation, 42 C.F.R § 413.40(e)(1), states that the adjustment request must be made within 180 days of the date on the NPR. The date on the Provider's NPR is inaccurate -- it does not reflect the date of which it is mailed to the Provider.

The Provider observes that it made a timely verbal request. The regulation governing the Provider's TEFRA adjustment request merely requires a provider's request to "be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement." 42 C.F.R. § 413.40(e)(1). There is no requirement that the request be made in writing.

The Provider contends that it did in fact give notice to the Intermediary that an adjustment would be required for FY 91. Notice was given to the Intermediary prior to the filing of the March 31, 1994 written adjustment request by virtue of the fact that the Provider had previously submitted requests for adjustments for prior cost years. These adjustment requests were all granted. Since HCFA authorized the Intermediary to make TEFRA adjustments after FY 88, the Intermediary had authority to make this adjustment on its own. Therefore, neither HCFA nor the Intermediary had to rely on a timely adjustment to make the necessary adjustments.

The Provider observes that due process mandates that the Provider receive the NPR prior to the running of the 180-day limitation period. Due process safeguards are applicable to Medicare reimbursement. Gray Panthers v. Schweiker, 652 F.2d 146, 152 n.15, 158, 167-72 (D.C. Cir. 1980). The Provider contends that the requirements of due process are violated by failing to give it the full 180-day period to which it is entitled, in order to prepare and submit its adjustment request. The Provider's due process claim must be evaluated under the test laid down by the Supreme Court in Mathews v. Eldridge, 424 U.S. 319, 335 (1976); Kraemer v. Heckler, 737 F.2d 214, 221 (2d Cir. 1984) (applying the Mathews v. Eldridge balancing test to due process challenges to Medicare reimbursement procedures).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that in its March 31, 1994 letter, the Provider requested an exception to the TEFRA target limit for the fiscal year ended September 30, 1991. The regulation governing requests for or adjustments to target limits is found at 42 C.F.R. § 413.40(e). Based on this regulation, a 180-day deadline is imposed on a provider that seeks relief to the TEFRA target limits. It is clear from the reading of this regulation that the date on the intermediary's NPR triggers the start of the 180-day count. The NPR at issue in this case is dated September 30, 1993 and is the basis for the controversy. The information below is related to the deadline and day count.

NPR Date	September 30, 1993
180 days from NPR Date	March 29, 1994
Date Provider's Request Received	April 5, 1994
Postmark Date of Provider's Request	March 31, 1994
# of Days from NPR to Receipt Date	187 days
# of Days from NPR to Postmark Date	182 days

The Provider's request was 187 days after the receipt date and 182 days after the postmark date. Therefore, the Intermediary denied the request for an exception since it exceeded the 180-day time frame and notified the Provider in a letter dated May 5, 1994.

The Intermediary states that the Provider did not submit with its request letter any of the required explanations or documentation to support the request. The Provider's documentation was not mailed to the Intermediary until August 1, 1994. This was 122 days after the request letter was filed. However, the Intermediary's denial was based on the initial letter.

The Intermediary observes that the Provider requested adjustments to the TEFRA target limits for the 1988, 1989, and 1990 fiscal years. The Provider filed the requests for these periods timely and, where warranted, adjustments were made. However, the granting of an exception to the TEFRA target limits is not automatic. The regulation states that a provider may request an exemption from, or an exception or adjustment to the target amount. Each request is reviewed on its own merit to determine whether it is timely filed, and whether documentation is sufficient to approve an adjustment. This means that the review and subsequent approval of adjustments

for the Provider's 1988, 1989 and 1990 fiscal years did not give the Provider automatic approval for the 1991 fiscal year. The request for each year had to be reviewed to determine whether it was timely filed, and whether the documentation submitted supported the approval of adjustments.

The Intermediary notes that the request for the 1991 fiscal year and the supporting documentation were sent along with the Intermediary's letter[8] to HCFA for its review and a decision. In its letter, the Intermediary recommended that the request be denied. HCFA reviewed the documentation and issued a response on November 25, 1997[9] denying the Provider's request for an adjustment because the request was not timely filed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence submitted, finds and concludes that the Intermediary properly denied the Provider's TEFRA exception request due to its untimely filing. The Board finds the regulation at 42 C.F.R. § 413.40(e)(i) language is clear and direct on its face. It states that a hospital's request must be received by the Intermediary no later than 180 days after the date on the intermediary's NPR. The Board finds the following facts as undisputed:

(1) Date of the original NPR was September 30, 1993.
(2) 180 days from the NPR date was March 29, 1994.
(3) Provider's request was postmarked March 31, 1994.
(4) Intermediary received the request on April 5, 1994.

The Board finds that the regulatory language of 42 C.F.R. § 413.40(e)(1) does not provide for any flexibility on the timing of receipt by the Intermediary of the Provider's request. The Provider contends that HCFA's policy allows the count of 180 days to begin seven days after the date on the NPR. The Board finds little evidence to support this contention. There are no HCFA guidelines or other interpretations to support this argument.

The Provider contends in an affidavit[10] that the Provider's consultant had telephone conversations with Intermediary personnel. Specifically, on March 30, 1994, the day the consultant became involved in this appeal, he recommended that the TEFRA adjustment appeal request be filed immediately. He stated that it was filed the next day. Further telephone conversations between the consultant and the Intermediary: (1) addressed the lack of logs of mail unless they are certified or registered and (2) HCFA's policy of allowing seven days for mailing time. These are testimonial commentaries that are uncorroborated and have limited value at best. The Board finds this argument unpersuasive. Further, the Provider's use of June 16, 1991 letter[11] from HCFA to Blue Cross and Blue Shield of Illinois to support its position that

[8] See Intermediary Exhibit 6.
[9] See Intermediary Exhibit 7.
[10] See Provider Exhibit P-4.
[11] See Provider Exhibit P-13.

HCFA allows a 7 days grace period in counting the 180 days time limit is not persuasive. First, the letter concerns filings in relation to different regulations. The letter addresses 42 C.F.R. § 413.40(h) while the regulation at hand in this case concerns 42 C.F.R. § 413.40(e). Second, the language of the letter is an informal interpretation of the regulation. The clear language of 42 C.F.R. § 413.40(e) is HCFA's official, formal statement of policy on the timeliness issue and is the appropriate authority on this issue.

Regarding the Provider's argument that the 180-day time limit should be the same for both TEFRA exception requests and the filing of Board appeals, the Board finds each regulation has specific language governing day count. The applicable regulation must be applied separately to each type of filing.

Regarding the Provider's desire to apply the legal doctrine of equitable tolling, the Board finds that the Provider had more than ample time to file for an exception request. It could have filed the request as early as the actual filing of the cost report in that the Provider had notice that it exceeded its TEFRA rates when the cost report was prepared. HCFA Pub. 15-1 § 3004.2 allows submission of the exception request with the submission of the "as-filed" cost report.

The Board finds no provision in the Medicare regulations which would permit the Provider an exception due to excusable neglect. The Provider had two prior requests and approvals and therefore had knowledge that a filing should have been made. Further, the Board finds that there is no evidence to support the Provider's contention that it made a verbal request to the Intermediary. Finally, the Board finds that the regulation is clear that the burden of filing an exception request on an annual basis is on the provider.

Based on the above findings, the Board concludes that the Intermediary acted properly in denying the Provider's TEFRA adjustment request due to its late filing.

DECISION AND ORDER:

The Intermediary properly denied the Provider's TEFRA exception request due to late filing. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire

DATE: July 17, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman

ISSUE:

Whether the Intermediary and HCFA[1] properly determined that the Provider's request for an adjustment to the TEFRA target limits was untimely.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Tax Equity and Responsibility Act of 1982, 42 U.S.C. § 1395ww(b) (TEFRA), established target limit costs which applied to all hospitals. HCFA issued regulations at 42 C.F.R. § 413.40 to implement the TEFRA requirements. Part of these regulations, 42 C.F.R. § 413.40(e)(i), establishes certain time requirements for providers to submit requests for adjustments to the rate-of-increase ceiling imposed under this section to the provider's fiscal intermediary. This case concerns the timeliness of the Provider's submission.

Section 1866(d) and (g) of the Social Security Act established Medicare's Prospective Payment System (PPS) for the inpatient services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983. This law was implemented by HCFA via Part 412 of the Medicare Regulations. Subpart A of Part 412 provides the general provisions of PPS. Subpart B provides provisions for hospital services which are subject to and excluded from PPS for inpatient operating costs. Specifically, 42 C.F.R. §§ 412.22-412.27 deal with issues relating to the requirements for excluded psychiatric units such as the Provider's.

The New Hanover Regional Medical Center (Provider) has a 40-bed, distinct-part PPS exempt psychiatric unit. This psychiatric unit exceeded its TEFRA target limit beginning in 1988. Its average length of stay (ALOS) had increased substantially over the ALOS in its TEFRA base year. The unit also had to add additional staffing.[2] For fiscal year ended September 30, 1988, (FY 88) HCFA granted the Provider's request for an adjustment to the TEFRA target limit. Because the Provider's operations had undergone a permanent change, it was foreseeable that annual adjustments would have to be made to accommodate these changes. HCFA, therefore, delegated its authority to Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina (Intermediary) to approve similar requests for adjustments using the same methodologies as those used for FY 88. Pursuant to its delegated authority, the Intermediary approved the Provider's request for adjustments to the TEFRA target limits for fiscal years ended September 30, 1989 and September 30, 1990.[3]

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The Provider appealed the Intermediary's determination of late filing under 42 C.F.R. § 413.40 to the Provider Reimbursement Review Board (Board). The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider is represented by Carel T. Hedlund, Esquire, of Ober, Kaler, Grimes and Shriver. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that pursuant to 42 C.F.R. § 413.40(e)(1), it made a timely request to review its exception request. Although the regulation suggests that a 180 day period within which a provider is required to make an adjustment request begins from the date of the NPR, HCFA has constantly construed and applied it to mean the date of receipt of the NPR by a provider. By allowing 7 days for mailing, the Provider would have had to make its adjustment request by April 4, 1994.

The Provider contends that the regulation presumes that the TEFRA request filing date is based on the premise that the NPR is mailed to the provider on the date it was dated. If the date on the NPR is different from the date of mailing, then the mailing date controls, and the 180 day limit begins from the mailing date. If the date of mailing is unknown, then the date receipt of the NPR by the provider will trigger the running of the 180 day period.

The Provider notes that in an analogous context, the regulation governing appeals to the Board, 42 C.F.R. § 405.1841(a)(1), requires a provider to make a request for a Board hearing within 180 days of the date the notice of the intermediary's determination was mailed to a provider. Significantly, however, this regulation has been consistently construed and applied by both HCFA and the Board to mean that the date of a provider's receipt of the NPR, actual or constructive, triggers the running of the 180-day appeal period. The Provider Reimbursement Manual, HCFA Pub. 15-1, § 2920.A.2 provides that the hearing request must be filed with the Board no later than the 180th calendar day following the date of receipt by the provider of the final determination.

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The Provider contends the Board should interpret the TEFRA regulation in the same way that the Board appeal regulation has been interpreted. A strict application of HCFA's and the Intermediary's construction of the timeless standard for a TEFRA adjustment request in this case would defeat "the ends of justice." Further, the Board should apply the doctrine of "equitable tolling." The Supreme Court has repeatedly approved the application of the "equitable tolling" doctrine to statutes of limitation to prevent unjust results.

The Provider contends that its failure to make its adjustment request within 180 days of the date of the NPR constitutes excusable neglect because the following circumstances are sufficiently misleading to cause a reasonable person to believe that the adjustment request had to be made only after receipt, actual or constructive, of the NPR. The attachment to the Provider's FY 91 NPR advising it of its right to appeal to the Board states that the appeal must be filed within 180 days of the date of the NPR. The TEFRA regulation, 42 C.F.R § 413.40(e)(1), states that the adjustment request must be made within 180 days of the date on the NPR. The date on the Provider's NPR is inaccurate -- it does not reflect the date of which it is mailed to the Provider.

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The Provider contends that it did in fact give notice to the Intermediary that an adjustment would be required for FY 91. Notice was given to the Intermediary prior to the filing of the March 31, 1994 written adjustment request by virtue of the fact that the Provider had previously submitted requests for adjustments for prior cost years. These adjustment requests were all granted. Since HCFA authorized the Intermediary to make TEFRA adjustments after FY 88, the Intermediary had authority to make this adjustment on its own. Therefore, neither HCFA nor the Intermediary had to rely on a timely adjustment to make the necessary adjustments.

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INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that in its March 31, 1994 letter, the Provider requested an exception to the TEFRA target limit for the fiscal year ended September 30, 1991. The regulation governing requests for or adjustments to target limits is found at 42 C.F.R. § 413.40(e). Based on this regulation, a 180-day deadline is imposed on a provider that seeks relief to the TEFRA target limits. It is clear from the reading of this regulation that the date on the intermediary's NPR triggers the start of the 180-day count. The NPR at issue in this case is dated September 30, 1993 and is the basis for the controversy. The information below is related to the deadline and day count.

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The Intermediary states that the Provider did not submit with its request letter any of the required explanations or documentation to support the request. The Provider's documentation was not mailed to the Intermediary until August 1, 1994. This was 122 days after the request letter was filed. However, the Intermediary's denial was based on the initial letter.

The Intermediary observes that the Provider requested adjustments to the TEFRA target limits for the 1988, 1989, and 1990 fiscal years. The Provider filed the requests for these periods timely and, where warranted, adjustments were made. However, the granting of an exception to the TEFRA target limits is not automatic. The regulation states that a provider may request an exemption from, or an exception or adjustment to the target amount. Each request is reviewed on its own merit to determine whether it is timely filed, and whether documentation is sufficient to approve an adjustment. This means that the review and subsequent approval of adjustments

for the Provider's 1988, 1989 and 1990 fiscal years did not give the Provider automatic approval for the 1991 fiscal year. The request for each year had to be reviewed to determine whether it was timely filed, and whether the documentation submitted supported the approval of adjustments.

The Intermediary notes that the request for the 1991 fiscal year and the supporting documentation were sent along with the Intermediary's letter[8] to HCFA for its review and a decision. In its letter, the Intermediary recommended that the request be denied. HCFA reviewed the documentation and issued a response on November 25, 1997[9] denying the Provider's request for an adjustment because the request was not timely filed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence submitted, finds and concludes that the Intermediary properly denied the Provider's TEFRA exception request due to its untimely filing. The Board finds the regulation at 42 C.F.R. § 413.40(e)(i) language is clear and direct on its face. It states that a hospital's request must be received by the Intermediary no later than 180 days after the date on the intermediary's NPR. The Board finds the following facts as undisputed:

(1) Date of the original NPR was September 30, 1993.
(2) 180 days from the NPR date was March 29, 1994.
(3) Provider's request was postmarked March 31, 1994.
(4) Intermediary received the request on April 5, 1994.

The Board finds that the regulatory language of 42 C.F.R. § 413.40(e)(1) does not provide for any flexibility on the timing of receipt by the Intermediary of the Provider's request. The Provider contends that HCFA's policy allows the count of 180 days to begin seven days after the date on the NPR. The Board finds little evidence to support this contention. There are no HCFA guidelines or other interpretations to support this argument.

The Provider contends in an affidavit[10] that the Provider's consultant had telephone conversations with Intermediary personnel. Specifically, on March 30, 1994, the day the consultant became involved in this appeal, he recommended that the TEFRA adjustment appeal request be filed immediately. He stated that it was filed the next day. Further telephone conversations between the consultant and the Intermediary: (1) addressed the lack of logs of mail unless they are certified or registered and (2) HCFA's policy of allowing seven days for mailing time. These are testimonial commentaries that are uncorroborated and have limited value at best. The Board finds this argument unpersuasive. Further, the Provider's use of June 16, 1991 letter[11] from HCFA to Blue Cross and Blue Shield of Illinois to support its position that

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The Board finds no provision in the Medicare regulations which would permit the Provider an exception due to excusable neglect. The Provider had two prior requests and approvals and therefore had knowledge that a filing should have been made. Further, the Board finds that there is no evidence to support the Provider's contention that it made a verbal request to the Intermediary. Finally, the Board finds that the regulation is clear that the burden of filing an exception request on an annual basis is on the provider.

Based on the above findings, the Board concludes that the Intermediary acted properly in denying the Provider's TEFRA adjustment request due to its late filing.

DECISION AND ORDER:

The Intermediary properly denied the Provider's TEFRA exception request due to late filing. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire

DATE: July 17, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman