PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D28

PROVIDER
St. Edward Mercy Medical Center
Fort Smith, Arkansas

Provider No.: 04-0062

vs.

INTERMEDIARY
BlueCross BlueShield Association/
Arkansas Blue Cross & Blue Shield

DATE OF HEARING -
July 31, 2003

Cost Reporting Period Ended -
June 30, 1994

CASE NO.: 97-1566

INDEX

ISSUE:

Was the Centers for Medicare and Medicaid Services' denial of the Provider's new provider exemption proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Saint Edward Mercy Medical Center (Provider) is an acute care hospital located in Fort Smith, Arkansas. The Provider established a certified skilled nursing facility (SNF) on its campus on July 20, 1993. The Provider claimed costs for the SNF on its fiscal year ended (FYE) June 30, 1994 cost report but did not limit its claimed costs to the SNF routine service cost limit (RCL). Arkansas Blue Cross and Blue Shield Association (Intermediary) issued a Notice of Program Reimbursement (NPR) on September 30, 1996, in which it applied the SNF RCL to the Provider's costs because the Provider did not have a new provider exemption to the RCL. The Provider subsequently requested a new provider exemption to the SNF RCL on March 4, 1997, Exhibit I-4, and on March 14, 1997 filed an appeal with the Board of the application of the SNF RCL to its FYE 1994 cost report. Exhibit I-1. The Board finds that the Provider filed a proper and timely appeal for the cost report at issue and has met the jurisdictional requirements of 42 C.F.R.

§§405.1835-405.1841.[1] The estimated amount of Medicare reimbursement is approximately $180,000.

The Provider submitted its request for exemption to the Intermediary on April 15, 1998. Exhibit P-10. The Intermediary did not forward the Provider's request to CMS until April 19, 1999. Exhibit I-5. The Intermediary indicated to CMS that the Provider had submitted the necessary documentation and completed the requisite questionnaire but did not make any recommendation concerning the Provider's request. Id.

In a June 29, 1999 letter to the Intermediary, CMS indicated that it had reviewed the information submitted by the Provider and found the exemption request to be incomplete, because the Provider failed to follow requirements #2 and #10 of the Fiscal Intermediary's Review and Recommendation Checklist. Exhibit I-6. The Provider did not include a copy of its Medicare Tie-In Notice, as required by item #2, and did not include a statement from its Director of Nursing (DON) attesting to the truthfulness of the dates of each skilled nursing or rehabilitative service that was first performed by the Provider, as required by item #10. CMS also requested that the Provider provide an explanation of and documentation to support its explanation, regarding two non-reimbursable cost centers, Mercy Towers and Nursing Home. The letter noted that the Intermediary was to deny the request because it was incomplete and was to instruct the Provider that it had 45 days from the date of the denial to submit a complete request. If the Provider submitted the information in time, it was to be considered part of the same request. If the Provider failed to submit the information in time, the Intermediary was to submit a recommendation to CMS that the exemption be denied based upon lack of documentation.

On July 7, 1999, the Intermediary sent a letter to the Provider asking for additional information concerning Mercy Towers and Nursing Home. The letter did not mention CMS' concern regarding items #2 and #10. See Exhibit I-7. The Intermediary indicated that the response had to be received by the Intermediary on or before August 21, 1999.

In a letter dated August 20, 1999, the Provider responded to the Intermediary's request for information. Because the August 21, 1999 deadline fell on a Saturday, the Provider requested and received an e-mail confirmation from the Intermediary indicating that the real deadline was Monday, August 23, 1999. Exhibit P-4.

In an e-mail dated January 17, 2000, the Provider asked the Intermediary to check on the status of its exemption request. See Exhibit P-8. In an e-mail response to the Provider dated January 18, 2000, the Intermediary replied that CMS said it had not received the information and indicated that it probably got lost in the mail. Id. The Intermediary said that it would send out the information again that week. However, the Intermediary did not submit the Provider's response to CMS until March 7, 2000. Exhibit P-6. In its

[1] The Intermediary 's position paper raised jurisdictional objections to the Board's review of this case. See Intermediary Position Paper at 5-8. At the hearing, the Intermediary indicated that it did not intend to pursue its jurisdictional challenge. Tr. at 18, lines 11-12.

letter, the Intermediary indicated that the Provider's response had been received by August 23, 1999.

In an e-mail from CMS to the Intermediary dated May 17, 2000, CMS indicated that it had asked for additional information from the Provider and had not received it. Exhibit P-5. In an e-mail response to CMS, the Intermediary indicated that it sent the information to CMS some time after it was received but was not sure when and therefore sent it again on March 7, 2000. Id. Since CMS still did not have the information, the Intermediary indicated that it would send it again. Id.

In a letter dated August 4, 2000, CMS denied the Provider's request for exemption. Exhibit I-9. The letter noted that the Intermediary had requested additional information from the Provider on July 7, 1999 and that the Provider had 45 days to submit a complete request. CMS stated that the Provider failed to timely submit the following documents as requested: the Medicare tie-in notice; statement from the DON; and the explanation and documentation concerning the non-reimbursable cost centers (NRCCs) - Mercy Towers and Nursing Home. The CMS denial was forwarded to the Provider by the Intermediary in a letter dated August 17, 2000. Exhibit I-10.

In a letter from the Intermediary to the Provider dated January 26, 2001, the Intermediary responded to the Provider's inquiries regarding the possibility that its exemption request may have been denied for reasons beyond its control. Exhibit P-9. In this letter, the Intermediary noted that the Provider requested a copy of the June 29, 1999 letter from CMS because it believed that it had been denied its exemption request based upon a failure to provide information that had never been requested. The letter noted that the CMS letter could not be found in the Intermediary's files and had to be requested from CMS. The letter also noted that the Intermediary advised CMS that it had not asked the Provider for all of the information requested by CMS. The Intermediary stated that, while CMS recognized that the Intermediary erred in not requesting all of the information it should have, the Provider had not supplied the information requested concerning the non-reimbursable cost center – Mercy Towers, and therefore, the Provider's request was incomplete and the decision was final.

In a letter to the Intermediary dated March 8, 2001, the Provider enclosed the following documents that the Intermediary had failed to include when it submitted Provider's SNF Exemption Request to CMS: (1) Provider's Medicare Tie-in Notice; (2) Statement from Provider's Director of Nursing; (3) Documentation regarding the Nursing Home and Mercy Towers NRCCs. The Provider requested that the Intermediary forward copies of Provider's letter and enclosures to CMS and ask for a reconsideration, as the denial was based on Intermediary procedural errors rather than on Provider's failure to furnish required documentation. Exhibit P-9.

The Provider was represented by William E. Gentry, Fiscal Services Director of the Provider. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

At the hearing, the Intermediary indicated that the problems with regard to the Medicare tie-in notice and DON statement had been resolved in favor of the Provider. Tr. at 24. However, the Intermediary asserts that the Provider's response to the request for information on the Nursing Home was not properly addressed by the Provider. The Intermediary claims that it had no obligation to help the Provider understand what CMS was asking for. The Nursing Home cost center was on the 1992 cost report that was part of the exemption request, and the Provider's response that it did not have a non-reimbursable Nursing Home cost center was inadequate.

The Provider asserts that it provided the requested information to the Intermediary and that the Intermediary never indicated that its response was incomplete. The Provider contends that it does not appear that the Intermediary ever forwarded the information to CMS nor did the Intermediary adequately explain to the Provider what CMS wanted so that a more specific response could be provided. The Provider also indicates that it would have been able to provide the necessary information had the Intermediary provided any guidance concerning what CMS wanted. Furthermore, it was the Intermediary that added the nursing home cost center to the settled 1992 cost report in anticipation of making an adjustment to disallow the cost associated with the Provider's nursing school students' rotations to a nursing home not owned by the Provider. There was no cost assigned to the cost center by the Intermediary, but the line was never eliminated. See Tr. at 56-57. The Provider also notes that the substantial delays in processing its exemption request made it impossible for it to resubmit a timely request after the denial.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that there were a number of problems with the manner in which the Intermediary and CMS handled the Provider's exemption request. The first problem is that the Intermediary delayed handling and forwarding the Provider's exemption request to CMS. The Provider submitted its exemption request to the Intermediary on April 15, 1998, but the Intermediary did not forward it to CMS until April 19, 1999. After the Provider's exemption request was reviewed by CMS on June 29, 1999 and deemed incomplete, the Provider submitted additional information to the Intermediary regarding the non-reimbursable cost centers, but it appears that despite the Intermediary's efforts to send their response to CMS, it had not been received by CMS as of May 17, 2000. See Exhibit P-5. After CMS' subsequent denial of the Provider's exemption request as incomplete on August 4, 2000, the Intermediary was unable to answer the Provider's questions about the denial until its letter dated January 26, 2001. See Exhibit P-9.

The second problem with the handling of the Provider's exemption request is that it is not clear whether the Intermediary sent all of the information submitted by the Provider to CMS. The Board notes that the Provider indicated in its letter of March 8, 2001 that it

sent the Medicare tie-in notice and the DON statement with the initial exemption request, and the answers regarding the non-reimbursable cost centers was sent on August 20, 1999. However, this information must not have reached CMS because both CMS' denial letters indicate that the Provider failed to provide the information on the Medicare tie-in notice and DON statement, and the second denial letter indicates that the Provider failed to answer its questions regarding the non-reimbursable cost centers. The Board notes that there is no evidence that CMS received the materials from the Provider before it made its denial decision (Tr. at 42, l 6-14) even though the Intermediary asserted that it did send the information to CMS and that it was considered by CMS. Tr. at 35, l 22-25. The Board further notes that in the Intermediary letter to the Provider dated January 26, 2001, See Exhibit P-9 on page 3, CMS acknowledged that the Intermediary had erred by not requesting all of the documentation requested by CMS from the Provider, but that this did not matter because the Provider had not supplied documentation to support its explanation of the non-reimbursable cost center Mercy Towers and, therefore, the request was not complete.

At the hearing, the Intermediary acknowledged that the issues with regard to the Medicare tie-in notice and DON statement had been resolved in the Provider's favor. Also, at the hearing, the Intermediary indicated that it was not claiming that the response it received from the Provider concerning the non-reimbursable cost centers was too late. Tr. at 32. Instead, the Intermediary now claims that there is only one problem with the Provider's exemption request – the Provider's inadequate response to the non-reimbursable cost center - Nursing Home. See Tr. at 25-29. The Board notes, however, that the Intermediary previously claimed the reason for the denial was concerns with the Provider's answers concerning Mercy Towers. See Intermediary Letter to Provider dated January 26, 2001, Exhibit P-5 at 3.

The final problem with the handling of the Provider's exemption request is that the Intermediary did not communicate CMS' concerns with the exemption request to the Provider so that it could provide additional information in a timely manner. As noted above, the Intermediary and CMS acknowledge that the Intermediary erred in not advising the Provider that CMS needed the Medicare tie-in notice and the DON statement. It also appears that the Provider was not aware that there was a problem with its response regarding the Nursing Home non-reimbursable cost center until just before the hearing. Tr. at 55. With regard to the information submitted by the Provider on the Nursing Home non-reimbursable cost center, the Board notes that the request for additional information regarding this matter could easily have been misunderstood by the Provider. The Provider assumed that CMS was referring to its 1994 cost report rather than its 1992 cost report, because no year was specified. Had the Intermediary or CMS provided any guidance concerning the request or indicated in a timely manner that the request was still incomplete, the Provider could have provided the additional information.

Based on these facts, the Board finds that the Provider submitted the Medicare tie-in notice, the DON statement and its responses to CMS' questions concerning the non-reimbursable cost centers in a timely manner. And, according to the Intermediary, this information was sent to CMS before it made its determination that the exemption request

was incomplete. On this basis, the Board finds that CMS' determination that the Provider's exemption request was incomplete was improper. Instead, CMS should have reviewed the materials submitted by the Provider and issued a determination on the merits of its initial request and the materials it subsequently submitted concerning the non-reimbursable cost centers.

DECISION AND ORDER:

The Board finds that the Provider's application was complete and that CMS' decision to reject the Provider's exemption request as incomplete was incorrect. The Board remands this matter to CMS to consider the Provider's exemption request on the merits.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: March 15, 2005

Suzanne Cochran, Esquire
Chairman