PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D17

PROVIDER -
Alden Court Nursing Home
Fairhaven, MA

Provider No.: 22-5387

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
November 18, 2005

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 99-3635

INDEX

ISSUE:

Whether CMS' denial of the Provider's request for an exception to the routine cost limits for skilled nursing facilities as a provider of atypical services was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to 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.

Section 1819(a)(1) of the Social Security Act defines a Skilled Nursing Facility (SNF) as an institution engaged in providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1888 of the Act established the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and also provides an exception to the limits for providers of "Atypical Services" at 42 C.F.R. §413.30(f). The issue in dispute in this appeal is whether the Provider is entitled to an exception under 42 C.F.R. §413.30(f) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Alden Court Nursing Home (Provider) is a Medicare-certified skilled nursing facility located in Fairhaven, Massachusetts. For fiscal years prior to 1996, the Provider had been granted several interim exceptions to the routine cost limits by Aetna, the Provider's prior intermediary and by Mutual of Omaha, its current intermediary (Intermediary). The Intermediary finalized the Provider's 1996 cost report on September 18, 1998 and

recommended a final cost limit exception of $72.50 to CMS on November 18, 1998. In a letter dated February 23, 1999, CMS granted a partial exception of $59.61 and questioned the remaining $12.89 (all of which was social services costs). CMS noted that these costs had increased by 67% from the prior year and requested that the Intermediary review these costs. The Intermediary, in turn, requested additional information from the Provider on March 10, 1999, with a 45- day deadline (April 24) for the Provider's response. In the interim, the Intermediary issued a revised NPR on March 23, 1999 with an RCL exception of $59.61 that was followed by a repayment demand letter. On April 6th, the Provider contacted the author of the 45-day letter to discuss the new NPR, and the Intermediary issued a letter of intent to reopen the cost report the same day. The Intermediary subsequently issued a revised NPR on May 10, 1999 with an RCL exception of $59.61 without any further input from the Provider. The Provider filed its appeal on July 29, 1999. At issue is the final disposition of the $12.89 social services cost differential.

PARTIES' CONTENTIONS:

The Provider contends that the social services exception of $12.89 should be allowed and argues that the Intermediary is authorized by regulations and CMS instructions, issued after September 1999, to make exception determinations without CMS approval. The Intermediary accepted and recommended the $12.89 social services exception in its November letter to CMS. Further, the Intermediary accepted and recommended the $12.89 exception for approval a second time to CMS as a result of its review of the Provider's response to the Intermediary's January 10, 2001 pre-hearing discovery request. The Provider contends that the Intermediary's recommendations should be the determinative factor in granting the exception.

The Provider also argues that CMS did not respond timely to the Intermediary's recommendation. Although CMS overrode the recommendation, it did not respond to that recommendation within the time limits set by the regulations. The Provider contends, therefore, that the Intermediary's determination should be final.

The Provider also contends that it responded timely to all of the Intermediary's requests. The Provider argues that the Intermediary issued a revised NPR on March 23, 1999 before the Provider could respond to the Intermediary's 45-day letter (dated March 10, 1999). The Provider asserts that it discussed the 45-day letter with the Intermediary on April 6 and could have responded to it before the April 24th deadline. However, the Intermediary's revised NPR represented a final determination and voided the original 45-day letter. The Provider responded timely to the NPR, which was the last and controlling communication received from the Intermediary.

The Intermediary contends that the social services exception of $12.89 should be disallowed and argues that the regulation in force at the time that the Provider filed its request required the Intermediary to file a recommendation with CMS (42CFR §413.30). Under the regulation, CMS retained final approval authority over the exception, and the Intermediary's recommendations are properly subordinate to CMS' denial determination.

The Intermediary also contends that CMS responded within the time limits set by PRM-15 and 42 CFR §413.30, which set 180 days from the time of receipt for CMS' response. The Intermediary argues that CMS responded within 90 days of its receipt and that its response was within the prescribed time limits.

The Intermediary further contends that the Provider did not respond to the Intermediary's 45-day letter as required by 42 C.F.R. §413.30. The Intermediary's argues that its authority to set a 45-day turnaround falls within the broad discretionary powers that Section 1886(a)(2) of the Social Security advanced to the Secretary in the administration of the program. The Provider's failure to respond places it in noncompliance with the regulations and makes the CMS disallowance final.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The circumstances of this case present two issues for the Board's consideration. The first involves the adequacy of the information supplied by the Provider to support its request for an exception as an atypical service provider. The second issue involves the impact of the administrative process upon the Provider's appeal rights.

To assess the adequacy of the Provider's exception request, the Board examined the Provider's submissions as well as other evidence in the record. The Board's examination of the Provider's initial submission indicated that it was prepared in sufficient detail and supported by adequate evidentiary materials to allow the Intermediary to accept the request and forward it to CMS with a positive recommendation. CMS responded with an initial rejection that was accompanied by a request for additional information. The Intermediary, in turn, made a request for the additional information in its March 10, 1999 letter and a second time, in its January 10, 2001 pre-hearing discovery request. The Board's examination of CMS' March request indicated that CMS' questions were matters of clarification, not completeness or accuracy. Consequently, it appears that the Intermediary's original determination remained unchallenged and correct throughout the clarification process. Further, the Intermediary accepted and recommended the $12.89 exception for approval to CMS a second time as a result of the Provider's response to the Intermediary's pre-hearing discovery request. The Board concludes that the evidence presented within the Provider's original application was sufficient to establish that the Provider qualified as a provider of atypical services under the requirements set at 42 C.F.R. §413.30(f).

The second issue presented for the Board's consideration concerns the impact of the administrative process upon the Provider's appeal rights. Specifically, the Board must assess the impact of the Provider's failure to respond to the Intermediary's March 10th request for information. The Intermediary finalized the Provider's 1996 cost report in September, 1999 and recommended a final cost limit exception to CMS in November. In

February, 1999 CMS returned the Intermediary's recommendation with a request for additional information on social services costs ($12.89 of the exception requested). The Intermediary, in turn, requested information from the Provider on March 10, 1999 and imposed a 45-day limit for its response. The 45-day request was impacted by a supervening event in the form of the revised NPR that was issued on March 23. Based upon conversations between the parties, the Intermediary issued a letter of intent to reopen the NPR. However, the Intermediary issued a revised NPR on May 10, 1999 without any additional input from the Provider. The Board's examination indicated that, despite the process breakdown, the Provider's original submission was complete, and the Intermediary had sufficient information to make its recommendation before requesting the data that CMS required. Further, the Provider responded to the Intermediary's January discovery request with sufficient clarity such that the Intermediary accepted and recommended the $12.89 exception for approval a second time to CMS. The Board finds nothing in the regulation that establishes a 45-day rule or indicates that the imposition of a 45-day turnaround compromises the Provider's appeal rights or precludes the Provider from filing additional information in support of its appeal. Consequently, the Board holds that the evidence presented within the Provider's original application was sufficient to establish the Provider's eligibility as an atypical service provider. The Board holds further that the Intermediary's second determination based upon the information filed during discovery was sufficient to resolve CMS' concerns and should have resolved the issue in the Provider's favor without the need for involvement by the Board.

The Board concludes that CMS' denial of the Provider's request for an exception to the routine cost limits for skilled nursing facilities was improper and that the Provider's request should be granted on the merits.

DECISION AND ORDER:

CMS' denial of the Provider's request for an exception to the routine cost limit was improper. The Provider's request should be granted on the merits.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

FOR THE BOARD:

DATE: February 17, 2006

Suzanne Cochran, Esquire
Chairperson