PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D45

PROVIDER -
Palmetto General Hospital – SNF
Hialeah, Florida

Provider No.: 10-5990

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
October 16, 2006

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 02-0162

INDEX

ISSUES:

Whether the Centers for Medicare and Medicaid Services (CMS) properly denied the request(s) of the Provider for an exemption from the Routine Service Cost Limits (RCLs) for the fiscal year ended December 31, 1998.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 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 portion 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 1861(v)(1)(A) established the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. These limitations are called routine cost limits (RCL) and are addressed in §§1861(v)(7)(B) and 1886(a) of the Social Security Act. 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and also identifies the circumstances under which a provider may qualify for an exception to or an exemption from the limits. 42 C.F.R. §413.30(c) sets the procedural limits for requests regarding the applicability of the cost limits and states in pertinent part that a SNF's "… must make its request to the fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement."

The issue in dispute in this appeal involves the proper application of the 180 day filing limit imposed under 42 C.F.R. §413.30(c) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Palmetto General Hospital - SNF (Provider) is a 15-bed, hospital-based skilled nursing facility which was certified to participate in the Medicare program on July 21, 1998. On September 13, 2000, Mutual of Omaha (Intermediary) issued an original NPR for its audit of the Provider's cost report for fiscal year ended December 31, 1989; however, the NPR did not impose any reimbursement reduction based upon the application of the RCLs. The Provider subsequently requested that the Intermediary reopen and revise the original NPR to reflect the application of the RCLs. The Intermediary issued a Notice of Reopening dated September 20, 2001, indicating its intent to revise the original NPR and incorporate the SNF RCLs.

In advance of the NPR's revision, the Provider filed a request for exemption from the RCLs with the Intermediary on April 25, 2001. The Intermediary forwarded the Provider's request with its affirming recommendation to CMS on June 27, 2001. CMS denied the request on October 12, 2001, and asserted that the request was not timely because it had not been filed within 180 days of the original NPR date. The Provider timely appealed the CMS determination to the Board on October 23, 2001.

On June 24, 2002, the Intermediary issued a revised NPR and applied the SNF RCL for the first time. Pursuant to the revised NPR, the Provider resubmitted its exemption request on July 1, 2002. CMS denied the second request as untimely, in respect to the original NPR date. The Provider timely appealed the second CMS denial to the Board on December 18, 2002. On January 13, 2003, the Board consolidated both appeals into one case. There is no dispute that the regulations at 42CFR §413.30 and the program instructions at PRM §2531.1.A are controlling. At issue is what action tolls the 180-day limit.

PARTIES' CONTENTIONS:

The Provider contends that both of its requests were timely filed and that CMS' denial of its request for exemption is based upon an improper application of the 180-day rule. Neither the regulations at 42 C.F.R. §413.30(c) nor the instructions in PRM-1, §2531.1.A limit the window in which to request an RCL exemption to 180 days from the date of the original NPR. The Provider argues that the Board has previously determined that the regulation at §413.30(c) "makes no distinction between original and revised NPRs,"[1] and that an exemption request to the routine cost limits could be filed by a SNF pursuant to the issuance of a revised NPR.[2] Accordingly, the Provider contends that its request for an exemption from the limits may be based on either an initial or a revised NPR.

The Provider also contends that there is no regulation or manual provision that limits the filing period for the exemption request solely to the 180 days following the original NPR.

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[1] Stanislaus Medical Center v. Blue Cross & Blue Shield Association/Blue Cross and Blue Shield of Ca., PRRB Hrg. Dec. No. 98-D79 (July 24,1998).

[2] Grace Nursing Home v. Blue Cross & Blue Shield Association/Trispan Health Services, PRRB Hrg. Dec. No. 2002-D5 (January 9,2002)

The Provider argues that CMS did include a specific provision for such a limitation at 42 C.F.R. §413.40(e)(1). This section details the procedure for hospitals requesting similar adjustments to their TEFRA rate-of-increase ceiling and requires that their requests be received by the intermediary "no later than 180 days after the date on the intermediary's initial notice of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment." (emphasis added). However, CMS did not use similarly restrictive language in 42 C.F.R. §413.30(c) and the Provider argues that "where particular language is included in one section of a statute but is omitted in another section of the same Act, it is generally presumed that Congress act[ed]intentionally and purposefully in the disparate inclusion or exclusion."[3] The Provider contends that had CMS intended such a limitation to apply to RCL exemptions, it could have and would have stated so in a regulation or manual provision.

The Provider also disputes the Intermediary's claimed distinction between a request for an exception and a request for an exemption and contends that, procedurally, exemption and exception requests are treated identically. The Provider notes that 42 C.F.R. §413.30(c)-(e) addresses both types of requests and states:

> "A SNF may request . . . an exception or exemption to the cost limits imposed under this section . . . [It] must make its request to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement."

The Provider also notes that PRM-I §2531.1.A.2 states that exemption or exception requests may be made "prior to the beginning of, during, or after the close of the affected cost reporting period." Accordingly, the Provider argues that there is no regulatory text or policy that supports the Intermediary's distinction between requests for exceptions and exemptions with respect to the application of the 180-day rule.

The Intermediary contends that the 180-day limit applies exclusively to the initial NPR and argues that 42C.F.R. §413.30(c) requires that a timely request for an exemption must be filed within 180 days from the date of the NPR that settled the cost report. The Intermediary acknowledges that PRM-1 §2531.1.A.2 states that exemption or exception requests may be made "prior to the beginning of, during or after the close of the affected cost reporting period." However, the Intermediary also argues that the Provider certified that it had filed its cost report correctly when it actually erroneous claimed that it had been granted an exemption from the cost limits in accordance with 42 C.F.R. §413.30(e). The Provider did not report its error until the 180-day limit had elapsed and, therefore, its request was not timely. The Intermediary contends that its application of the RCLs or the lack thereof has no bearing on whether a request meets the 180-day timely filing requirement. Rather, CMS bases its review of timeliness of the request for exemption to the date of the initial NPR. Therefore, a revised NPR which reopens the cost report for a specific issue has no bearing on the Provider's rights to request an exemption.

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[3] SEC v. McCarthy, 322 F.3d 650, 656 (9th Cir. 2003).

The Intermediary also argues that an exemption cannot be requested based upon a revised NPR, and that it is CMS' policy to limit requests based upon revised NPRs to exception requests where there has been an update to the cost limit for that particular cost reporting period.

The Intermediary continues that CMS' policy is consistent with the regulations, and that the omission of "initial" within the regulations is not the result of any statute that clearly demonstrates a different meaning.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The issues presented for the Board's consideration involve two separate requests for an exemption from the SNF RCLs. While both requests are subject to the 180-day rule at 42 C.F.R. §413.30(c), each was filed to accommodate the specific set of circumstances that existed within the settlement process at the time of its filing. Accordingly, the Board's findings will address each filing separately.

The Provider claimed its total costs as reimbursable on its as-filed 1998 cost report, and the Intermediary issued its original NPR without any RCL adjustments on September 13, 2000. The Provider subsequently requested that the Intermediary reopen the original NPR to apply the RCLs. The Intermediary agreed to the reopening and, in advance of the NPR's revision, the Provider filed its first request for an exemption from the RCLs on April 25, 2001. The Provider contends that the request was timely filed because an exemption request may be made "prior to the beginning of, during, or after the close of the affected cost reporting period."[4] The Intermediary asserts that the request must be filed "within 180 days of the date on the intermediary's notice of program reimbursement that settled the cost report."[5] The Board's examination of the statute and regulations indicates that both require that a request must be filed within the 180-day deadline. Although the instructions in PRM-I allow a filing anytime before, during or after the cost reporting period, the section lacks legal sufficiency to override the statute or regulations and must, therefore, operate consistently with the law. When the regulations and instructions are read and applied collectively, the Board finds that the Provider may file its request at any time prior to the beginning of, during, or after the close of the affected cost reporting period so long as the filing is made within 180-days of the date on the NPR. The Provider's first request for an exemption to the RCL was filed well beyond 180 days of the date of the original NPR, accordingly, the Board concludes that the Provider's first filing was not timely and that CMS properly denied it.

On June 24, 2002, the Intermediary issued its revised NPR and applied the SNF RCL for the first time. Pursuant to the revised NPR, the Provider submitted its second exemption request on July 1, 2002. CMS denied the second request as untimely based upon the

[4] PRM-I §2531.1.A.2
[5] 42 C.F.R. §413.30(c)

determination it made on the Provider's first request. The Provider contends that prior Board decisions have held that a request for an exemption or an exception from the RCLs may be based on either an initial or a revised NPR. The Provider argues that its filing was timely because it was filed within 180-days of the issuance of a revised NPR. The Intermediary contends that the 180-day limit applies exclusively to the initial NPR which settled the cost report and that an exception can only be requested based upon an original NPR. The Intermediary argues that the Provider's second request was well beyond 180 days of the initial NPR and, therefore, is not timely.

The Board's examination of the regulations and manual instructions does not support the Intermediary's conclusion that the 180-day limit applies exclusively to the initial NPR that settled the cost report. Nowhere in the language of either does that limitation appear. Further, the Board finds no support for the Intermediary's argument that an exemption cannot be requested based upon a revised NPR. The Board found no regulation or policy that supports the Intermediary's claimed distinction between requests for exceptions and exemptions with respect to the application of the 180-day rule.

The Board has previously determined that the regulation at §413.30(c) makes no distinction between original and revised NPRs[6] and that an exception request to the RCLs could be filed by a SNF pursuant to the issuance of a revised NPR.[7] Since both the regulations and program instructions treat exceptions and exemptions the same procedurally, the Board concludes that the Provider may file an exemption request pursuant to a revised NPR within 180-days of the date the revised NPR was issued. The Provider filed its second request for exemption to the RCLs well within the 180-day limit; therefore, it was filed timely. The Board finds that CMS' determination denying the Provider's second request as untimely was improper and that the request should be remanded to CMS for a determination on its merits.

The Board reached its conclusions based upon its application of the regulations and program instructions to the collective record before it. However, the Board notes that both parties raised complaints relative to each other's handling of the exemption requests. Both parties to this appeal are familiar with the requirements of the Medicare regulations. Those regulations are presented in such sufficient detail that both parties should have known their respective duties and responsibilities within the settlement and exemption processes. Nevertheless, in its as-filed cost report, the Provider certified that it had been granted an exemption when, in fact, it had not. The Intermediary seeks the Board's action to redress the Provider's error. However, there is nothing in the regulations that allows the Board to punish the Provider for its mistake any more than there is authority for the Board to grant a provider equitable relief when it is warranted. Further, the Intermediary should have known which of its providers have exemptions in place but it apparently did not. The Intermediary also failed to detect the Provider's error in claiming

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[6] Stanislaus Medical Center v. Blue Cross & Blue Shield Association/Blue Cross and Blue Shield of Ca., *Supra*.

[7] Grace Nursing Home v. Blue Cross & Blue Shield Association/Trispan Health Services, PRRB Hrg. Dec. No. 2002-D5 (January 9,2002)

that it had an approved exemption in place. Consequently, the Board limits its findings to the determinations of timeliness articulated above.

DECISION AND ORDER:

The Provider's filing for an exemption to the routine cost limits pursuant to the original NPR was not timely, and CMS properly denied it.

CMS' denial of the Provider's request for an exemption based on the revised NPR was improper. The Board remands the request to CMS for a determination of the request on its merits

Board Members Participating:

Suzanne Cochran, Esquire (Recused)
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: July 02

Elaine Crews Powell, C.P.A.