PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2010-D9

PROVIDER -
City of Hope National Medical Center
Duarte, California

Provider No.: 05-0146/05-7037

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Services Option, Inc.

DATE OF HEARING -
February 12, 2009

Cost Reporting Period Ended -
September 30, 1996

CASE NO.: 00-3325

INDEX

ISSUE:

Whether the Provider timely filed its Tax Equity and Fiscal Responsibility Act (TEFRA) exception request.

MEDICARE STATUTORY AND PROCEDURAL HISTORY:

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 to organizations 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. §1395h, 42 C.F.R. §§413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs 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.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase in inpatient operating costs recoverable by a hospital. *See* Section 101 of the TEFRA, Pub. L. No. 97-248, 96 Stat. 339, 42 U.S.C. §1395ww(b). Generally, the TEFRA ceiling amount, or target amount per discharge, is calculated based upon the allowable Medicare operating costs in a hospital's base year divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually. If a provider's actual cost per discharge is below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement of its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount. The regulation implementing TEFRA, 42 C.F.R. §413.40, establishes the procedure and criteria for providers to make requests to CMS for exemptions from, and exceptions and adjustments to, the TEFRA ceiling.

On October 1, 1983, Congress amended the Social Security Act and adopted a new payment system known as the Prospective Payment System (PPS)for the operating costs of inpatient hospital services. 42 U.S.C. §1395ww(d).[1] However, hospitals designated as cancer hospitals were exempted from Medicare PPS if they met the requirements of the regulation at 42 C.F.R. §412.23(f). The Provider in this case met the requirements to be designated a cancer hospital subject to the TEFRA limits.

A provider subject to TEFRA limits may request an exemption from or an exception to the TEFRA rate of increase limit within 180 days of the NPR "where events beyond the hospital's control or extraordinary circumstances . . . create a distortion in the increase in costs for a cost reporting period" or where the Secretary otherwise "deems appropriate." 42 U.S.C. §1395ww(b)(4)(A); 42 C.F.R. §413.40(e). The provider's request "must be received by" the intermediary no later than 180 days after the date on the intermediary's initial NPR. 42 C.F.R. §413.40(e)(1). After such request, the fiscal intermediary makes a recommendation to CMS and either CMS or the Intermediary makes the decision. 42 C.F.R. §413.40(e)(2), (3). This decision is subject to administrative and judicial review in accordance with the Medicare statute and regulations. 42 C.F.R. §413.40(e)(4).

The dispute in this case is over the timeliness of the Provider's request for an exception to the TEFRA limits.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The City of Hope National Medical Center (Provider) is a hospital located in Duarte, California. The Provider met the criteria under the regulation at 42 C.F.R. §412.23(f) to be designated a cancer hospital and was exempted from Medicare PPS during the fiscal year ended (FYE) September 30, 1996. United Government Services, LLC- California (Intermediary)[2] issued an NPR to the Provider for FYE 1996 dated September 30, 1998. On March 29, 1999, exactly 180 days after the date of issuance of the NPR, the Provider deposited with an overnight courier its TEFRA adjustment request for FYE 1996. The Intermediary received the Provider's request on March 30, 1999.

On April 24, 1999, the Intermediary sent its recommendation to CMS to deny the Provider's request due to the Provider's failure to timely file their request.[3] On February 17, 2000, CMS sent its response agreeing with the Intermediary's recommendation.[4] On March 9, 2000, the Intermediary informed the Provider about CMS' response denying the Provider's exception request.[5]

The Provider timely appealed the denial to the Board under 42 C.F.R. §413.40(e)(4)(ii).

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[1] Under PPS, most hospitals are paid a prospectively determined amount for their inpatient operating costs based on national and regional rates for each patient's diagnosis at the time of discharge.
[2] First Coast Services Option, Inc. is the current intermediary for the Provider.
[3] Exhibit I-6.
[4] Exhibit I-7.
[5] Exhibit I-8.

The Provider was represented by Kathleen H. Drummy, Esquire, of Musick, Peeler & Garrett, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider argues that its request was timely filed and that the Intermediary's and CMS' interpretation of the regulation is inconsistent with the Medicare Act. The Provider does note that CMS changed the regulation in 1995 to require that requests be "received by" the intermediary within 180 days; however, the Provider asserts that CMS took the position in the preamble, 60 Fed. Reg. 45841 (September 1, 1995), that "timely filing of an exception request should be consistent with [timely filing under] Section 1878 of the Act," 42 U.S.C. §1395oo, governing appeals made to the Board.

The Provider notes that Section 1878 of the Act sets forth the conditions which must be satisfied in order for a Medicare provider to obtain a hearing before the Board. It states that: "[the] provider files a request for a hearing within 180 days after notice of the intermediary's final determination." 42 U.S.C. §1395oo(a)(3) In addition, CMS codified the definition of the term "date of filing" as used in Section 1878 of the Act, 42 U.S.C. §1395oo, to mean "the day of the mailing (as evidenced by the postmark) or hand-delivery of materials." 42 C.F.R. §405.1801(a) (emphasis added.)

The Provider states that CMS inexplicably relied upon Black's Law Dictionary rather than its own codified regulation to define the term "file," as the date of receipt by the intermediary. *See* 60 Fed. Reg. at 45841. This interpretation conflicts with the Section 1878(a)(3) of the Act and 42 C.F.R. §405.1801(a) and where there is a conflict, the previous regulation, as opposed to a non-codified dictionary definition, should be adhered to. Under the proper standard, with filing being defined as mailed or postmarked on the 180th day, the Provider has submitted a timely TEFRA request.

The Provider also points out that two other CMS regulations concerning deadlines do not require that the request or appeal be "received" to meet the deadline. With respect to requests for reclassification, exceptions and exemptions from cost limits, the request only has to be "made" within 180 days. *See* 42 C.F.R. §413.30(c). With respect to requests for payment rate exceptions for dialysis services the "facility must request an exception to its payment rate within 180 days." *See* 42 C.F.R. §413.180(d).

Finally, the Provider notes that it currently has an appeal pending for FYE 1996, Case No. 99-2388, which includes an issue "target amount updated," in recognition that the target amount will change as a result of successful appeals for prior years. Thus, payments under the TEFRA limit are already under appeal with the Board and the Board has the discretion to review the Provider's entitlement to the exception request as part of that appeal.

The Intermediary contends that its recommendation to CMS to deny the Provider's TEFRA exception request was due to the Provider's untimely filing of the request. Even

though the Provider mailed its request on March 29, 1999, the Intermediary states that it did not receive the request until March 30, 1999.[6] This was 181days following the original NPR dated September 30, 1998. Therefore in accordance with 42 C.F.R. §413.40(e)(1), the Provider's request was not timely.

In CMS' letter dated February 17, 2000, it agreed with the Intermediary and stated the following:

> Under the regulations at 42 C.F.R. §413.40(e)(1), the hospital's request for an adjustment to the TEFRA limit must be received by the fiscal intermediary no later than 180 days from the date of the initial Notice of Program Reimbursement. We agree with your recommendation that any adjustment request for FY 1996 be denied due to untimely filing of the hospital's request.[7]

The Intermediary asserts that its determination was correct under the regulation and should be affirmed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The timeliness of a request for an adjustment to the TEFRA rate of increase is governed by 42 C.F.R. §413.40(e)(1). The Board notes that prior to October 1, 1995, §413.40(e)(1) provided:

> A hospital may request an adjustment to the rate-of increase ceiling imposed under this section. The hospital's request to its fiscal intermediary may be made upon receipt of the intermediary's notice of amount of program reimbursement (NPR) and must be made no later than 180 days after the date on the intermediary's NPR for the cost reporting period for which the hospital requests an adjustment. (emphasis added.)

This earlier regulation did not define the term "made" thus making the deadline ambiguous. The term "made" could plausibly mean either the date the request was sent or mailed, or the date that the request was received by or filed with the intermediary. Because of this ambiguity, CMS issued a clarifying amendment to the regulation. *See* 60 Fed. Reg. 45840 (Sept. 1, 1995). In the preamble to the revision, CMS stated that it was changing the wording in §413.40(e)(1) from "made" to "received by" in order to clarify CMS' consistent interpretation that requests for adjustments had to be received by the hospital's intermediary no later than 180 days from the date of the NPR. *Id*. at 45840. The final rule preamble stated:

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[6] Exhibit I-5.
[7] Exhibit I-7.

> We proposed to revise §413.40(e)(1) to clarify that a request for a payment adjustment must be *received* by a hospital's fiscal intermediary no later than 180 days from the date of the notice of program reimbursement (NPR). Currently, this section states that a request must be "made" rather than "received." We have consistently interpreted the word "made" to mean "received by the fiscal intermediary" since the original regulation was promulgated (47 FR 43282, September 30, 1982). However, use of the word "made" in §413.40(e)(1) has resulted in varying interpretations of the timely filing requirement by hospitals and their fiscal intermediaries. In the interest of a uniform and consistent application of our policy, we proposed to clarify the regulation by substituting "received by the hospital's fiscal intermediary" for "made" in §413.40(e)(1).

60 Fed.Reg. 45778, 45840 (Sept. 1, 1995).

Thus, effective October 1, 1995, 42 C.F.R. §413.40(e)(1) was amended to read:

> A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's initial notice of amount of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment. (emphasis added).

The Provider points out that a CMS comment in the preamble to the regulation appears to be inconsistent with its requirement in the regulation for exception requests to "be received" by the Intermediary within 180 days of the initial NPR. CMS stated that "we believe our policy with regard to the timely filling should be consistent with section 1878 of the Act." 60 Fed. Reg. 48541 (Sept. 1, 1995). Section 1878 of the Act deals with provider appeals to the Board, which contains a requirement that the "provider files a request for a hearing within 180 days after notice of the Intermediary's final determination." 42 U.S.C. §1395oo(a)(3). CMS has defined the "date of filing" as used in Section 1878 of the Act to mean "the day of the mailing (as evidenced by the postmark) or hand delivery of materials." 42 C.F.R. §405.1801(a). Regardless whether an inconsistency exists in the preamble language, the CMS regulation states that the request "must be received" no later than 180 days after the date of the initial NPR. Under 42 C.F.R. §405.1867, the Board must comply with the regulation and any determination that the regulation is contrary to the statute and therefore invalid is reserved for the federal courts.

The Board finds that since 1995 CMS has clearly stated in both the preamble language and the language of the regulation that TEFRA exception requests must be received by the fiscal intermediary no later than 180 days after the date of the intermediary's initial NPR. Since the Provider's request was not received within 180 days of its NPR, the Board finds that the Intermediary's determination to deny the Provider's request as untimely was correct.

DECISION AND ORDER:

The Intermediary's determination that the Provider's TEFRA request was untimely was proper. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: January 5, 2010