PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D46

PROVIDER -
Davies Medical Center
San Francisco, California

Provider No.: 05-0008

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
First Coast Service Options, Inc.
(formerly United Government Services)

DATE OF HEARING -
March 6, 2008

Cost Reporting Period Ended -
December 31, 1983

CASE NO.: 97-0206

INDEX

ISSUE:

Whether the Intermediary properly denied the Providers Tax Equity and Fiscal Responsibility Act (TEFRA) exception request because of the timeliness of the request.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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. §1395h, 42 C.F.R. §§413.20 and 413.24.[1]

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.[2] 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.

From the Medicare program's inception in 1966 until 1982, hospitals were reimbursed the lower of their reasonable costs or customary charges for service provided to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1); see generally Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248, 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 per case recoverable by a hospital. Generally, the TEFRA ceiling amount, or target amount, 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 incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for 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 for a particular year. The regulation implementing TEFRA, 42 C.F.R. §413.40,

[1] These sections were codified as 42 C.F.R. §§405.402, 405.406 and 405.403 in 1983, the year in issue.
[2] Previously codified as 42 C.F.R. §405.406(b).

establishes the procedure and criteria for providers to make requests to CMS for exemptions from and adjustments to the TEFRA ceiling.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Davies Medical Center (Provider) is a short-term hospital located in San Francisco, California. The Intermediary had proposed an adjustment to amend the TEFRA Target limit from $5,141.49 (per as-filed cost report) to $5,153.82, to agree with the audited base year report.[3] Subsequently, as part of a partial administrative resolution dated December 4, 1995 which resolved Issue Number 12 of the Provider's PRRB Case No. 85-0178 (also for FY 83), the Intermediary proposed a reopening adjustment that recomputed the cost per discharge. Issue Number 12 involved the count of available beds, and the resolution agreed to include 46 beds that were omitted in the original computation of the TEFRA target rate.[4] As a result, the Intermediary reopened the cost report to amend the cost per discharge, and modified it from $5,153.82 to $5,168.14 in the revised NPR dated January 31, 1996.[5] On July 26, 1996, the Provider wrote to the Intermediary requesting an exception to the TEFRA target limit.[6]

On July 29, 1996, the Provider appealed the correctness of the TEFRA target rate limitation to the Board.[7] On August 16, 1996, the Intermediary wrote to the Provider, denying the exception request for two reasons.[8] First, on the Revised NPR dated January 31, 1996 the only issue revised related to available beds. The Intermediary stated that the issue of available beds was completely unrelated to the criteria that the Provider had to satisfy in order to obtain an exception to the TEFRA target rate. Those criteria included atypical nursing and other costs, which bore no relation to the issue of available beds. Second, even if the Provider was justified in appealing the TEFRA target rate, the appeal request should have been filed within 180 days of the revised NPR dated January 31, 1996, which expired on July 30, 1996. The Intermediary did not receive a copy of the Provider's appeal request until after that date, and so the request was not timely. Accordingly, for the Provider to have a valid appeal relating to the issue of an exception request, the appeal should have been filed within 180 days of the initial NPR, which had an adjustment amending the TEFRA target rate.

The Provider was represented by Thomas J. Weiss, Esquire, of Weiss and Hunt. The Intermediary was represented by Bernard M. Talbert, Esquire, of BlueCross BlueShield Association.

---

[3] See Intermediary Exhibit I-1.
[4] See Intermediary Exhibit I-2.
[5] See Intermediary Exhibit I-3 and provider Exhibit P-1.
[6] See Intermediary Exhibit I-5 (addressed by reference only).
[7] See Intermediary Exhibit I-4.
[8] See Intermediary Exhibit I-5.

PARTIES' CONTENTIONS:

The Provider contends that 42 C.F.R. §405.1889 indicates that a provider has appeal rights regarding items reflected on a revised NPR issued under §405.1885. The Intermediary made a determination in issuing a revised NPR in 1996. Furthermore, under 42 C.F.R. §405.463(e) a provider can seek an exception based on the Intermediary's adjustments. The Provider contends this regulation does not limit exception requests to requests filed within 180 days of the initial NPR.

The Provider further contends that there is no support in the Medicare regulations for the Intermediary to conclude there is a distinction between an initial and revised NPR as it relates to an appeal of the Intermediary's denial of an exception request. If a provider is forced to obtain an exception only for the amounts reflected in a revised NPR, rather than seek exceptions for the entire target rate problem, it would be forced to contest every single reopening, thus multiplying appeals over insignificant amounts. The cost report year is open, not an individual issue, per an initial or revised NPR. Finally, the Provider states that Care Unit Hospital of Dallas (Fort Worth, Texas) v. Mutual of Omaha, PRRB Dec. No. 95-D26, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶43,222 supports its position. In that case the Board found that 42 C.F.R. §405.1889 is not an appropriate basis for denying a provider's exception request relative to a revised NPR. In that case the Board found that exception requests are governed by 42 C.F.R. §413.40. The Board held that 42 C.F.R. §405.1889 did not control.

The Intermediary contends that CMS Pub. 15-1 §2920 requires that a provider's request for a Board hearing must be filed with the Board no later than the 180th calendar day following the NPR. Where a provider files an appeal in response to a reopening adjustment, the appeal is limited to the issues reopened. In this instant case, only the count of beds was addressed in the reopening, so only that issue can be addressed in this appeal.

The decision in French Hospital Medical Center v. Shalala DC No. CV-92-03527-EFL (9th Cir. 1996) supports the Intermediary's position that the Provider can appeal only those issues that have been revised. Further, CMS Pub. 15-1 §2921 requires a provider to identify for appeal specific individual items in the NPR with which it disagrees. The Intermediary interprets this to mean that when a provider files an appeal relating to a specific NPR, it can appeal only the substance of the adjustments in that (revised) NPR.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, program instructions, the parties' contentions and evidence submitted, the Board finds and concludes that the Provider had a right to file its application for an exception within 180 days from the Revised NPR but its filing was not timely. In reaching its conclusion, the Board addressed the following questions: (1) whether the Provider's request for an exception was filed on a timely basis (2) whether the Provider may apply for an adjustment to a rate of increase ceiling within 180 days

after issuance of a revised NPR, and if so, (3) whether the resulting adjustment must be limited to items addressed in the revised NPR.

The regulation in effect at the issuance of the Provider's initial NPR (1983) 42 C.F.R §405.463(e) stated as follows:

> (e) *Hospital requests regarding applicability of the rate-of-increase ceiling*. A hospital may request an exemption from or exception to the rate of cost increase ceiling imposed under this section. The hospital's request must be made to its fiscal Intermediary no later than 180 days from the date on the Intermediary's notice of amount of program reimbursement.

The regulation in effect at the time of the revised NPR dated January 31, 1996, 42 C.F.R. §413.40(e) states:

> (e) *Hospital requests regarding adjustments to the payment allowed under the rate-of-increase ceiling*. (1) *Timing of application*. 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 regulation in effect at the time the initial NPR was issued posed no limitation on the type of NPR (initial or revised) from which a hospital may request an exception. Effective in 1995, the regulation was changed to limit a provider's exception request to an initial NPR.

Although the amended regulation was in effect when the Intermediary issued the revised NPR in January 1996, the Board finds that the Provider could not have complied with the new rule effective in 1995, which was 10 years after the original NPR was issued on March 29, 1985 because the 180 day time limit from the original/initial NPR would have long passed.

Further, the application of the 1995 revision limiting the hospital's request to be made within 180 days from the initial NPR effectively would have cut off a provider's right to make such a request. The Board concludes that the revised regulation would apply only to initial NPRs issued on or after the effective day of the revised regulation.

With regard to whether adjustments to the rate-of-increase ceiling must be limited to items addressed in the revised NPR, the Board finds no basis for limiting the relief from a revised NPR to the incremental increase only. 42 C.F.R. §405.1889 states:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This section deals exclusively with the appeal rights of providers pursuant to a revised NPR but clearly imposes no threshold limits on the scope of the provider's exception request. 42 C.F.R §413.463(e) sets the procedural limits for exception requests to its fiscal Intermediary within 180 days of the date on the Intermediary's NPR. The regulation makes no distinction between types of NPR and provides no basis upon which to limit relief for a request. Accordingly, the Board concludes that under the applicable regulations, a provider is allowed to make an exception request to the rate of increase ceiling for any amount within 180 days of any NPR in which the RCL is at issue. There is no basis to limit a provider's exception request to the effect of issues adjusted in a revised NPR.

With regard to timeliness of requesting an exception to the rate of increase ceiling, the regulation in effect in 1995 states:

> 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.

The Board finds that the Provider's request for an exception was received more than 180 days after the date of the revised NPR. Intermediary's position paper, p. 3 and also Exhibit I-5. The Provider did not challenge the Intermediary's assertion.

The evidence showed that the Provider had filed a request prior to the one in issue here which was rejected by the Intermediary apparently as being deficient. The Board requested further information from the Provider regarding the initial request to determine if it may have met the time limit and possibly tolled the time period in which to file. The Provider did not respond to the request, however, the Board draws an inference from the Provider's failure to respond that the information sought by the Board would not have been favorable to the Provider.

DECISION AND ORDER:

The Provider had a right to file an exception request from the Revised NPR but failed to file it within 180 days. Its application was, therefore, untimely. The Intermediary's denial of exception is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 17, 2010