

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D45

PROVIDER -
Good Shepherd Rehabilitation Hospital
Bethlehem, Pennsylvania

Provider No.: 39-3050

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Highmark Medicare Services-PA
(Formerly Veritus Medicare Services)

DATE OF HEARING -
January 26, 2011

Cost Reporting Period Ended -
June 30, 2003

CASE NO.: 05-1802

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ISSUE:

Whether the Intermediary properly reimbursed the Provider based on the blended rate for inpatient rehabilitation facilities (IRF) versus the 100 percent federal prospective payment system (PPS) rate for IRFs.

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. *See* 42 U.S.C. § 1395 *et seq.* 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs¹ determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. §§ 1395h, 1395kk-1; 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. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. The 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). *See* 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. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

From the Medicare program's inception in 1965 until 1982, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1). The Medicare statute was subsequently amended by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") to modify the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. 42 U.S.C. § 1395ww(b).

Under the TEFRA payment methodology, a provider was paid on the basis of reasonable cost subject to a rate of increase ceiling on its inpatient operating costs ("reasonable cost/TEFRA principles") per discharge. The TEFRA limit, or target amount, was calculated based on the allowable Medicare operating costs in a hospital's base year (net of certain other expenses including capital-related and medical education costs) divided by the number of Medicare

¹ FIs and MACs are hereinafter referred to as intermediaries.

discharges in that year. For new inpatient rehabilitation facilities, which lacked historical cost data, the statute specified that the TEFRA limit was:

110 percent of the national median (as estimated by the Secretary) of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C) . . .

42 U.S.C. § 1395ww(b)(7)(A); *See also* 42 C.F.R. § 413.40(f)(2)(ii).

Accordingly, under the reasonable cost/TEFRA principles, a new inpatient rehabilitation facility would be reimbursed at the lower of the hospital's net operating costs per discharge or the TEFRA limit, calculated using an adjusted national median target amount. *Id.*

When Congress subsequently created a prospective payment system ("PPS") for acute care hospitals in the Social Security Amendments of 1983, it specifically excluded inpatient rehabilitation hospitals and distinct part units from this system. By 1997, however, Congress amended the Medicare statute to require CMS to implement PPS for inpatient hospital rehabilitation services provided by IRFs. *See* Balanced Budget Act of 1997 ("BBA"), Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410-414 (1997) (Provider's Exhibit P-48).² Recognizing a need to "phase in" the new payment system, the initial bill called for a three-year transition period for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, under which an existing provider would receive payment based on a combination of payment amounts computed based on its existing reasonable cost/TEFRA amount and the new PPS Payment Rate ("Blended Rate"). H. CONF. REP. NO. 105-217, 1997 U.S.C.C.A.N. at 371-373 (1997) (Provider's Exhibit P-50). This transition period was subsequently shortened by Conference Amendment – to end as of October 1, 2002 – demonstrating Congress' desire to implement PPS payments as soon as possible. *Id.*

Pursuant to the BBA provisions, the prospective payment system was to be fully implemented by October 1, 2002, and for cost reporting periods beginning on or after that date, all IRFs would receive payment based on 100% of the federal PPS payment rate. *Id.* (codified at 42

² The legislative history explained the historical growth of payments to IRFs and the exigent need to implement a PPS system:

Between 1990 and 1994, Medicare payments to rehabilitation hospitals and units more than doubled from \$1.9 billion to \$3.9 billion. At the Health Subcommittee hearing on April 10, 1997 on Medicare payments to Rehabilitation facilities, several experts testified regarding problems with the current payment method and the feasibility of implementing a prospective payment system in the near future. The Committee believes that a prospective payment system would increase efficiency and *should be implemented as soon as possible.*

H.R. REP. 105-149, at 1320 (1997) (emphasis added) (Provider's Exhibit P-49).

U.S.C. § 1395ww(j)(1)(B)). The statute, however, had specific provisions intended to ease the transition to a new payment methodology. The statute provided:

- (1) PAYMENT DURING THE TRANSITION PERIOD.—
- (A) IN GENERAL. – Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a ‘rehabilitation facility’), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of –
- (i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and
 - (ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997) (codified at 42 U.S.C. § 1395ww(j)(1)(A)) (Provider’s Exhibit P-48).

As referenced in the foregoing, the following payment percentages were to apply during the transition period as part of the mechanism to pay IRFs based on a blended rate:

- (C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.--For purposes of subparagraph (A), for a cost reporting period beginning—
- (i) on or after October 1, 2000, and before October 1, 2001, the ‘TEFRA percentage’ is 66 2/3 percent and the ‘prospective payment percentage’ is 33 1/3 percent; and
 - (ii) on or after October 1, 2001, and before October 1, 2002, the ‘TEFRA percentage’ is 33 1/3 percent and the ‘prospective payment percentage’ is 66 2/3 percent.

Id. (codified at 42 U.S.C. § 1395ww(j)(1)(C)).

Payments based on a blended rate were intended to permit IRFs that had previously received reimbursement under reasonable costs/TEFRA principles to adjust to PPS. *See* 66 Fed. Reg. 41316, 41368 (Aug. 7, 2001) (Provider’s Exhibit P-21). The statute did not specifically address the application of the transition payment methodology to new rehabilitation facilities,

i.e., those that were not enrolled in the Medicare program prior to the transition period and which had never received payments computed under reasonable cost/TEFRA principles.

The Medicare statute was further amended by the Benefits Improvement and Protection Act of 2000 (“BIPA”) to permit IRFs to elect out of the blended rate during the transition period. *See* Pub. L. No. 106-554, § 305, 114 Stat 2763, at 495 (2000) (Provider’s Exhibit P-51). Specifically, Section 305(b)(1)(C) of BIPA added the following subsection:

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.--A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) [Fully Implemented System providing for 100% of the federal PPS payment rate] (rather than subparagraph (A) [Transition Period providing for blended rate]) for each cost reporting period to which such payment methodology applies.

Id. (codified at 42 U.S.C. § 1395ww(j)(1)(F)).

The legislative history of this provision states that Congress intended that “[a] rehabilitation facility would be able to make a one-time election before the start of the PPS to be paid based on a fully phased-in PPS rate.” *See* Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Provider’s Exhibit P-22).

Due to delays in developing PPS for IRFs, CMS delayed the implementation of the PPS regulations until January 1, 2002 and, accordingly, the blended rate applied only for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002. 66 Fed. Reg. at 41317 (Provider’s Exhibit P-21). Similar to the statute, the Medicare regulations did not explicitly address new facilities which had never received reimbursement based on reasonable cost/TEFRA principles. *See generally* 42 C.F.R. § 412.600 *et seq.* Medicare regulations provided for payments to be made to IRFs during the transition period based on the blended rate, as follows:

Duration of transition period and proportion of the blended transition rate. (1) Except for a facility that makes an election under paragraph (b) of this section, for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, an inpatient rehabilitation facility receives a payment comprised of a blend of the adjusted Federal prospective payment . . . and a facility-specific payment as determined under paragraph (a)(2) of this section.
(i) For cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002, payment is based on 33 1/3

percent of the facility-specific payment and 66 2/3 percent of the adjusted FY 2002 Federal prospective payment.

42 C.F.R. § 412.626(a)(1) (Provider's Exhibit P-23).³

The regulations also provide for an IRF to elect to be paid based entirely on PPS during the transition period. Those regulations require an IRF to submit a payment election to its fiscal intermediary to be paid at 100% of the federal PPS payment rate at least 30 days before its first cost reporting period for which the transition period payments would apply. 42 C.F.R. § 412.626(b).⁴

The dispute in this case involves the proper election of the 100 percent federal PPS rate for new IRFs.

³ With respect to calculation of the "facility-specific payment," the regulations provide:

The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital-related costs in accordance with part 413 of this subchapter.

42 C.F.R. § 412.626(a)(2) (Provider's Exhibit P-23). Part 413 of the regulations sets forth the principles of cost-based reimbursement, including the methodology for calculating TEFRA amounts at 42 C.F.R. § 413.40 (2002) (Provider's Exhibit P-47). Under that provision, a new rehabilitation hospital is reimbursed at the lower of: (1) the hospital's net inpatient operating cost per case; or (2) 110 percent of the wage adjusted national median target amount – or "TEFRA limit." *Id.* at § 413.40(f)(2)(ii); 66 Fed. Reg. 39828, 39916, 40038 (Aug. 1, 2001) (Provider's Exhibit P-53).

⁴ The payment election provisions state as follows:

(b) *Election not to be paid under the transition period methodology.* An inpatient rehabilitation facility may elect a payment that is based entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates

42 C.F.R. § 412.626(b) (Provider's Exhibit P-23).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Good Shepherd Rehabilitation Hospital--Bethlehem (Provider or Good Shepherd) was an IRF located in Bethlehem, Pennsylvania. The Provider received its Medicare enrollment as a new IRF on November 18, 2002, with enrollment being effective as of September 24, 2002.⁵ On December 5, 2002 the Provider sent a letter electing the Fully Federal Prospective Payment System.⁶ On December 11, 2002 CMS instructed Veritas Medicare Services (Intermediary) through an email that the election for IRF PPS payment was untimely.⁷ On January 8, 2003 the Intermediary sent a letter to the Provider notifying them they would be reimbursed on the blended rate for IRFs.⁸ The Provider requested reconsideration by CMS of its denial of Good Shepherd's election to receive 100 percent of the adjusted federal PPS rate as untimely.⁹ On September 30, 2004 the Provider requested CMS Division of Survey & Certification to change the date of certification for the Provider from September 24, 2002 to October 1, 2002 as an alternative basis to be reimbursed the 100 percent federal PPS rate.¹⁰ On November 2, 2004 CMS denied that request.¹¹ On January 5, 2005 the Intermediary issued an NPR reimbursing the Provider on the blended rate for IRFs instead of the 100 percent federal PPS rate.¹² Highmark Medicare Services-PA has since assumed the responsibility as Intermediary for the Provider. On June 30, 2005, the Provider filed an appeal with the PRRB for its fiscal year ended (FYE) June 30, 2003. The Provider estimates the reimbursement amount in dispute to be \$463,892.¹³

The Provider timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840. The Provider was represented by Robert E. Mazer, Esquire and Kristin C. Carter, Esquire of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider believes the blended payment rate used by the Intermediary during the transition period does not apply to new IRFs. The Provider agrees the applicable statute and regulation do not specifically mention new IRFs and how they are to be treated during the transition period. However, the Provider asserts it has shown clear intent by Congress that transition payments should not apply to new IRFs since they had never been reimbursed under the reasonable cost TEFRA methodology and did not require a transitional period to adjust from

⁵ See Provider's Exhibit P-8.

⁶ See Provider's Exhibit P-10.

⁷ See Intermediary's Exhibit I-7.

⁸ See Provider's Exhibit P-12.

⁹ See Provider's Exhibit P-13 and P-14.

¹⁰ See Provider's Exhibit P-15. The effect of this change would eliminate Medicare reimbursement for the period of September 24, 2002 through September 30, 2002 and reimburse the Provider on 100 percent federal PPS rate beginning October 1, 2002.

¹¹ See Provider's Exhibit P-16.

¹² See Intermediary's Exhibit I-4.

¹³ See Provider's Position Paper, p. 2.

the cost based system. The Provider contends it should be reimbursed the 100% Federal PPS payment rate since a transition is not needed for new IRFs.

The Provider argues that even if the transition payment methodology applies to IRFs that had not previously received payment based on their own reasonable cost – which it contends it does not – the Intermediary improperly ignored Good Shepherd’s election to be paid at 100% of the Federal PPS payment rate. The Provider argues that it was Congress’ intent to permit every rehabilitation facility to have the opportunity to elect to be paid on the 100% Federal PPS payment rate. Therefore, the statute and regulations should not be applied in a way that makes it impossible for new IRFs to elect to be paid 100% Federal PPS payment rate.

The Provider notes that the Intermediary’s requirement that a timely election be made on or before August 24, 2002, i.e., 30 days before commencement of its first cost reporting period, would have been impossible for the Provider to meet.¹⁴ The Provider offers several arguments as to why it could not meet the August 24, 2002 election deadline. The Provider states that the letter dated November 18, 2002 was the first time it was advised of its assigned fiscal intermediary and Medicare provider number.¹⁵ The Provider believes that it needed this information in order to make an election of the 100% Federal PPS payment rate that met the Intermediary’s August 24, 2002 deadline. Furthermore, the Provider argues it could not have been aware of the August 24, 2002 deadline until it was notified of its September 24, 2002 certification date which was also in the November 18, 2002 letter. *Id.* Because the Provider’s certification date was based upon an unannounced survey,¹⁶ it was impossible for the Provider to have anticipated the date without being told and knowing it would pass the survey.

The Provider states that it was not informed through formal Medicare startup training, the statute, or the regulations that the election for the 100% Federal PPS payment rate needed to be made prior to its being enrolled in the Medicare program.¹⁷ Congress intended for IRFs to have an opportunity to elect payment based on 100% of the Federal PPS payment rate. (*See*, Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 §305 Provider’s Exhibit P-22) and the Provider asserts it always intended to be paid based on the 100% Federal PPS payment rate. The Provider believes it exercised its statutory – and regulatory – right to elect to have Medicare payments for its first cost reporting period based on the 100% Federal PPS payment rate. *See* 42 C.F.R. § 412.626(b) (Provider’s Exhibit P-23).

The Provider argues it is clear that the Intermediary’s application of the regulations would create a virtually insurmountable burden for a new Medicare provider to obtain rights to elect to be paid based on the 100% Federal PPS payment rate conferred under the statute and regulations. It should, therefore, be rejected. *See generally Comet Enters. v. Air-A-Plane Corp.*, 128 F.3d 855, 859 (4th Cir. 1997) (court well-advised to construe regulations to avoid “serious constitutional questions”) (Provider’s Exhibit P-35). The Provider asserts under established legal principles, statutory requirements should not be applied strictly where

¹⁴ *See* Provider’s Exhibits P-11, P-16, and P-18.

¹⁵ *See* Provider’s Exhibit P-8.

¹⁶ *See* Provider’s Exhibit P-27, Transcript (Tr.) pp. 89-90.

¹⁷ *See* Tr. pp. 46-47, Provider’s Exhibit P-43 pp. 11-92.

compliance would be factually impossible, or where such a statutory interpretation would otherwise lead to an absurd, unjust or unintended result. *See Hughey v. JMS Dev. Corp.*, 78 F.3d 1523 (11th Cir.), *reh'g en banc denied*, 89 F.2d 857 (11th Cir.), *cert. denied*, 519 U.S. 993 (1996) (Provider's Exhibit P-33);¹⁸ *United States v. Mendoza*, 574 F.2d 1373 (5th Cir. 1978) (finding "drafters failure to fine tune the rule caused . . . policies to become discordant") (Provider's Exhibit P-34).

The Provider believes the regulation that requires a request for payment based on the 100% Federal PPS payment rate be received by the Intermediary at least thirty (30) days before the commencement of the applicable cost reporting period *may* be a valid regulatory requirement, as applied to entities participating in Medicare when the election is required to be made. However, the Provider argues this regulation was not properly promulgated as applicable to entities seeking certification as new Medicare providers.¹⁹

Finally, the Provider believes CMS' denial of its request to delay its certification date until October 1, 2002 was arbitrary and capricious.²⁰

INTERMEDIARY'S CONTENTIONS:

The Intermediary believes the statute, 42 U.S.C. § 1395ww(j), unambiguously sets the election deadline missed by the Provider. The Intermediary points specifically to 42 U.S.C. § 1395ww(j)(1)(F) which states:

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.--A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

The Intermediary argues the statutory language "rehabilitation facility" is broad and excludes qualifiers or exceptions that may exempt the Provider from the election deadline.

The Intermediary asserts that where an agency's statutory construction is challenged, courts employ a two-step process: first, they ascertain whether Congress has spoken to the issue; if the answer to that first question is uncertain, then courts determine if the agency's construction is permissible under the statute. To answer the first question, courts employ traditional tools of statutory construction, looking first to the statutory language and then, if necessary, to the legislative history. *INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987); *see also*

¹⁸ The *Hughey* Court referred to the principle "*Lex non cogit ad impossibilia*: The law does not compel the doing of impossibilities." 78 F.2d at 1530.

¹⁹ *See* Provider's Post Hearing Brief pp. 22-24.

²⁰ *See* Provider's Post Hearing Brief pp. 24-25.

Brock v. Writers Guild of America, West, Inc., 762 F.2d 1349, 1353 (9th Cir.1985) (“In construing a statute in a case of first impression, [courts] look to the traditional signposts of statutory construction ...”). Thus, the first step in statutory construction is application of the plain meaning rule. *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340, (1997) (citing *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 240, (1989); also see, *Catholic Social Services, Inc. v. Meese*, 664 F. Supp. 1378, 1382 -1383 (E.D.Cal.,1987). If the statutory language is clear and unambiguous, “ ‘that language must ordinarily be regarded as conclusive,’ [citation omitted]”. *North Dakota v. United States*, 460 U.S. 300, 312 (1983).

The Intermediary continues, the interpretation of a statute by the agency charged with its administration is also one of the traditional tools employed to determine Congressional intent. *Brock v. Writers Guild of America*, 762 F.2d 1349, 1353 (9th Cir. 1985). However, where the statutory language is perfectly clear, there is no need to examine the regulatory or legislative history, and other tools of statutory construction. Congressional intent is ordinarily embodied in the text of the statute. *Fuller v. United States*, 615 F. Supp. 1054, 1057 (E.D. Ca. 1985), *rev'd on other grounds*, 786 F.2d 1437 (9th Cir.1986). Thus, administrative interpretation, an extrinsic aid to construction, is only relevant where examination of the text leaves an unresolved ambiguity.

The Intermediary notes the regulations mirror the statutory requirement. The Intermediary argues the legislative history supplied by the Provider²¹ “sheds little light” on the issue in this case. The Intermediary concludes neither Congress nor the agency provided for any exception to the 30 day election deadline.

The Intermediary believes it followed the applicable deadline imposed by the statute for the election by the Provider of the 100% federal PPS rate. The Intermediary argues the statute itself provides more than adequate notice to the Provider of the need to file its election of the 100% Federal PPS rate in a timely manner.

The Intermediary asserts there were multiple alternatives available to this Provider to elect the 100% Federal PPS rate. The Intermediary argues the Provider should have heeded the notice provided by the statute, reiterated in the applicable regulation, and proactively protected its interests. Instead, the Provider allegedly sought to rely on the advice of one member of the Intermediary staff as a basis to not comply with the election requirements. The Intermediary believes the Provider’s actions failed to seek, record, or document the key requirement – the filing of a written request for election of the 100% Federal PPS rate in a timely manner.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties’ contentions, the Board finds and concludes that the Intermediary properly reimbursed the Provider under the blended rate for inpatient rehabilitation facilities.

²¹ See Provider’s Exhibit P-22.

The Board finds both the statute and the regulation speak directly to the issue of when an election request for the 100 percent federal PPS rate for IRFs must be made. 42 U.S.C. § 1395ww(j)(1)(F) states:

(F) ELECTION TO APPLY FULL PROSPECTIVE PAYMENT SYSTEM.--A rehabilitation facility may elect, not later than 30 days before its first cost reporting period for which the payment methodology under this subsection applies to the facility, to have payment made to the facility under this subsection under the provisions of subparagraph (B) (rather than subparagraph (A)) for each cost reporting period to which such payment methodology applies.

If this election is not properly made 42 U.S.C. § 1395ww(j)(1)(A) requires the IRF to be paid the blended rate utilized by the Intermediary.²²

The Board finds the regulation at 42 C.F.R. § 412.626(b) also supports the Intermediary's determination. The payment election provisions state as follows:

(b) *Election not to be paid under the transition period methodology.*
An inpatient rehabilitation facility may elect a payment that is based

²² 42 U.S.C. § 1395ww(j)(1)(A)-(C) states:

- (j) Prospective payment for inpatient rehabilitation services
 - (1) Payment during transition period
 - (A) In general

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a "rehabilitation facility"), other than a facility making an election under subparagraph (F) in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of--

- (i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A of this subchapter with respect to such costs if this subsection did not apply, and
- (ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) Fully implemented system

Notwithstanding section 1395f(b) of this title, but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, or, in the case of a facility making an election under subparagraph (F), for any cost reporting period described in such subparagraph, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) TEFRA and prospective payment percentages specified

For purposes of subparagraph (A), for a cost reporting period beginning--

- (i) on or after October 1, 2000, and before October 1, 2001, the "TEFRA percentage" is 66 2/3 percent and the 'prospective payment percentage' is 33 1/3 percent; and
- (ii) on or after October 1, 2001, and before October 1, 2002, the "TEFRA percentage" is 33 1/3 percent and the "prospective payment percentage" is 66 2/3 percent.

entirely on the adjusted Federal prospective payment for cost reporting periods beginning before fiscal year 2003 without regard to the transition period percentages specified in paragraph (a)(1)(i) of this section.

(1) *General requirement.* An inpatient rehabilitation facility will be required to request the election under this paragraph (b) within 30 days of its first cost reporting period for which payment is based on the inpatient rehabilitation facility prospective payment system for cost reporting periods beginning on or after January 1, 2002 and before October 1, 2002.

(2) *Notification requirement to make election.* The request by the inpatient rehabilitation facility to make the election under this paragraph (b) must be made in writing to the Medicare fiscal intermediary. The intermediary must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates

42 C.F.R. § 412.626(b).

The Board finds the applicable cost reporting period began September 24, 2002²³ making the election request due 30 days prior to that date. The Board finds the Provider sent a letter electing the “Fully Federal Prospective Payment System” on December 5, 2002.²⁴ Therefore, the election request was not made within the 30 day period, in accordance with the statute and regulation. Absent a proper election the Provider is paid the blended rate for inpatient rehabilitation facilities. *See* 42 U.S.C. § 1395ww(j)(1)(A).

Even though the Board empathizes with the Provider’s arguments related to new providers having to make an election before they become certified under the Medicare program, the Board finds the statute and regulation silent regarding any exception or exemption of new providers from the election deadline. The Board finds the statutory language clear on its face and therefore does not need look to Congressional records for intent.²⁵

Finally, the Board does not make a finding on the Provider’s arguments that CMS’ denial of its request to delay its certification date until October 1, 2002 was arbitrary and capricious.²⁶ The Board’s jurisdiction is generally found in the statute at 42 U.S.C. § 1395oo(a) and the regulations at 42 C.F.R. §§ 405.1835 – 405.1840. The Board finds that the decision to deny the Provider’s request to change its “effective date of participation” made by CMS’ Northeast Consortium/Division of Survey & Certification²⁷ does not fall within the jurisdictional power granted the Board.

²³ *See* Provider’s Exhibit P-8.

²⁴ *See* Provider’s Exhibit P-10.

²⁵ *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340, (1997) (citing *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 240, (1989); *also see, Catholic Social Services, Inc. v. Meese*, 664 F. Supp. 1378, 1382 -1383 (E.D.Cal.,1987), *North Dakota v. United States*, 460 U.S. 300, 312 (1983).

²⁶ *See* Provider’s Post Hearing Brief pp. 24-25.

²⁷ *See* Provider’s Exhibit P-16.

DECISION AND ORDER:

The Intermediary properly reimbursed the Provider based on the blended rate for inpatient rehabilitation facilities (IRFs). The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Michael W. Harty

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: September 15, 2011