CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
Citrus Health and Rehabilitation Center **Provider**	**Medicare Reimbursement** **Fiscal Years Ending: 05/31/96, 05/31/97, and 05/31/98**
vs.	**REVIEW OF:**
Mutual of Omaha Insurance **Intermediary**	**PRRB Dec. No. 2003-D40** **Dated: July 29, 2003**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. CMS' Center for Medicare Management (CMM) requested review of the Board decision. Subsequently, the parties were notified that the Administrator would review the Board's decision, and the Provider submitted comments. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether CMS properly denied the Provider's request for an exemption from the Medicare skilled nursing facility (SNF) routine cost limits (RCL) as a new provider under 42 CFR 413.30(e) based on CMS' determination that the exemption request was not timely filed.

The Board found that CMS improperly denied the Provider's request, as there was substantial evidence in the record that the Provider filed an exemption request with its Intermediary on January 6, 1995. The Provider's testimony at the hearing supported its claim that it express-mailed the request to the Intermediary on January 6, 1995, "faxed" the request to the Intermediary in 1996, and hand-delivered the request to the Intermediary in 1997. Furthermore, the Board observed that the Provider's current

Intermediary admitted in correspondence to CMS[1] that the Provider's 1995 request had never been forwarded to CMS by the prior intermediary.[2] The Board noted that both the prior and the current intermediary reimbursed the Provider as if a new provider exemption had been granted, in its first two cost years, i.e., in fiscal years ending (FYE) 05/31/95 and 05/31/96.

The Board also noted that, although the record contains no documentation of the Intermediaries' actions taken pursuant to the Provider's exemption request, the record indicates that the Provider complied with the application requirements in the regulations and the Provider Reimbursement Manual (PRM), and that the Provider was not responsible for the "deficiencies that later materialized during the review and decision-making process." Thus, the Board maintained that, either the Intermediary granted the Provider's request without CMS approval, or the records related to the approval process were lost. Either way, the Board found that the later actions taken by the Intermediary and CMS, leading to the Provider's appeal, were arbitrary and capricious.

In addition, the Board concluded that the Provider's January 6, 1995 exemption request, even though submitted in the form of a memorandum, was proper in form and language, and was sufficiently documented. Neither the regulations nor the PRM prescribes the form and language which a request must follow and both Intermediaries understood the purpose of the Provider's memorandum. The Board also pointed out that §413.30(e) supports the Provider's right to request an exemption for multiple cost years in one request. Finally, the Board noted that a May 31st year-end has been consistently used by the Provider and Intermediary throughout the cost years at issue. In sum, the Board vacated the Intermediary's denial of the Provider's exemption request and remanded the request for review and a determination on the merits.

SUMMARY OF COMMENTS

CMM requested that the Administrator reverse or modify the Board's decision to indicate that the Provider's January 6, 1995 document did not meet the requirements for an exemption request established at §2531 of the PRM, and, thus, was invalid for exemptions effective in FYEs May 31, 1995 through May 31, 1998. CMM emphasized that, as held by the Administrator in Twin Rivers Regional Medical Center,[3] the new provider exemption is not automatically applied for three full years. A provider is

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[1] CMS was called the Health Care Financing Administration (HCFA) during the cost years at issue; however, for the sake of consistency, "CMS" will be used throughout this decision.

[2] The record reflects that the Provider's prior intermediary was Aetna Life Insurance Company.

[3] CMS Adm. Dec. May 29, 2002.

required to request an exemption for each cost year. The Provider did not due so in its January 6, 1995 request.

CMM further advised that CMS has issued new decisions based upon the Provider's new exemption requests that meet the requirements of §2531 of the PRM, for FYEs May 31, 1995 through May 31, 1998. Thus, CMM concluded, the reimbursement issue in this case is moot.

The Provider commented that, although CMM stated that "'[t]he reimbursement issue in this case is moot,'" the Provider received "no official notification" that the disputed exemptions have been approved by CMS. However, the Provider included in its comments a copy of a letter dated August 13, 2003 from CMS to the Intermediary indicating that exemption relief was granted. The Provider also argued that the regulation at §413.30(e) establishes that an exemption may apply to multiple cost reporting periods, and contemplates that an exemption would be in effect for the entire period permitted in the regulation. Nothing in the regulations even implies that separate requests for each cost year must be made, and the Provider's witness testified at the hearing that multiple-year exemption requests have been accepted by CMS. This principle is also consistent with §2533.1A of the PRM. The Provider noted that, at the hearing, the CMS witness maintained that a rule requiring separate cost year exemption requests was "'implied'" in §2533.1A; however, nothing in the language of the PRM provision supports this contention. The Intermediary, in fact, recommended approval of the single request, for multiple years, to CMS, and the Provider had been reimbursed consistent for more than one cost year based upon this single request.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and included in the record.

The Administrator first notes that, as CMM pointed out in its comments, a provider is required to request an exemption for each applicable cost year, although multiple years may be requested in the same exemption request. See e.g. Twin River Regional Medical Center, PRRB Case Nos. 96-0211, 97-1061, and 98-2080. Similarly, a provider has a right to a Board hearing under section 18778(a)(1)(A)(i) of the Social Security Act, under the routine cost limits (RCL), of the total amount of reimbursement due the provider (usually reflected in the Notice of Program Reimbursement or NPR). Because the appeal of the NPR is the vehicle for Board jurisdiction under the reasonable cost methodology, the regulation at 42 CFR 413.30 explains that the time for CMS to review a provider exemption request is good cause for granting an extension of time to apply for Board review as specified under 405.1841. Thus, a provider's appeal of CMS' determination on a RCL exemption request, is reflected in both the statutory and

regulatory scheme,. as ultimately an appeal from an NPR for a particular cost year See, e. g., Larkin Chase Nursing and Restorative Care Center, PRRB Case No. 98-0388 and 00-3079. Accordingly, a provider's right to a Board hearing for a particular cost year on the new provider exemption issue is dependent upon the cost years designated in the provider's original exemption request.

In this case, the Board reversed CMS' finding that the Provider had filed an untimely request. The Board found that the Provider had in fact filed a timely multiple year new provider exemption request. The Board remanded the Provider's January 6, 1995 exemption request to CMS for a determination on the merits. However, as reflected in both CMM's and the Provider's comments, CMS has, in the interim, rendered a determination on the Provider's new provider exemption requests for FYEs 1995, 1996, 1997, and 1998 by letter dated August 13, 2003. This determination incorporates the Provider's January 6, 1995 exemption request and was based upon the same material facts and documents set forth in this case.

Accordingly, the Administrator finds that as CMS has rendered a determination on the Provider's exemption requests on the merits, the Board's remand to CMS is moot. As noted by CMS, if the Provider is dissatisfied with CMS' determinations on the merits of the Provider's new provider exemption requests, dated August 13, 2003, the Provider may appeal CMS' determination to the Board in accordance with 42 CFR 413.30(c). Accordingly, the Board's decision is modified in accordance with this decision

DECISION

The decision of the Board is modified in accordance with the foregoing decision.

THIS CONSTITUTES THE FINAL DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 9/11/2003

/s/

Leslie V. Norwalk
Acting Deputy Administrator
Centers for Medicare and Medicaid Services