PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D47

PROVIDER -Neumann Medical Center
Philadelphia, PA

Provider No. 39-0023

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
December 2, 1997

Cost Reporting Period Ended -
June 30, 1991

CASE NO. 96-2128

INDEX

ISSUE:

Was the Provider's request for additional adjustment payments for routine and ancillary services under 42 C.F.R. § 413.40(g)(3) timely?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Neumann Medical Center ("Provider") is an acute care hospital located in Philadelphia, Pennsylvania. It had a distinct part psychiatric unit in fiscal year ended June 30, 1991 ("FY 91") that was exempt from Medicare's prospective payment system for inpatient operating costs. The Provider's operating costs for that unit were subject to the ceiling on the rate of increase.

The parties have stipulated and agreed to the following facts:

1. The Provider's fiscal Intermediary, Ætna Life Insurance Company ("Intermediary"), issued the original Notice of Program Reimbursement ("NPR") for the FY 91 cost report on November 12, 1993.

2. The reimbursement of the Provider's psychiatric unit reflected on the NPR referenced in stipulation #1 above was computed based on a per discharge limit on reasonable cost reimbursement ("TEFRA Limit") which combined the unit's base year cost per discharge updated for inflation ($4,066.74) ("Base Amount") and an adjustment for the distortion of operating costs experienced by the psychiatric unit due to an increased length of stay of $6,600.78 per discharge ("Adjustment Amount") for total TEFRA Limit of $10,667.52.

3. The Provider initially calculated the adjustments to which it was entitled to be $217,827.00, the full amount of the TEFRA limit penalty in FY 91. However, based on the final adjustment calculations for increased routine and ancillary services that were granted to the Provider by HCFA and the Intermediary for FYs 92 - 96, which included adjustments for routine and ancillary services, the Provider now calculates the additional adjustment payments to which it would ultimately be entitled, if the appeal request was considered on its merits, to be approximately $100,000.

4. The adjustment amount reflected an adjustment for the distortion of operating costs experienced by the unit since its base year, and it was computed based on one of the factors that 42 C.F.R. § 413.40(g)(3)(i) specifies as a basis for such an adjustment, the increased length of stay experienced on the unit since its base year.

5. On April 19, 1994, the Intermediary notified the Provider of a revised base amount and adjustment amount.

6. On April 21, 1994, HCFA notified the Provider of its intent to reopen the Provider's FY 91 cost report to properly state the TEFRA limit for the psychiatric unit.

7. The base amount was recalculated and reduced from $4,066.74 to $4,027.01 by using a different inflation factor (1.055 as opposed to 1.0544335) and a "freeze factor" of .9897.

8. The adjustment amount was then recalculated using the reduced base amount. The use of the reduced Base Amount resulted in a reduction of the Adjustment Amount from $6,600.78 to $6,536.29.

9. The two calculations combined referenced in stipulation 8 resulted in a reduction of the TEFRA Limit by approximately $100.00.

10. On April 29, 1994, the Intermediary issued a Correction Notice of Program Reimbursement ("Revised NPR") which used the revised target limit of $10,563.30 to compute an increased penalty under the TEFRA limit for the unit of $16,780.00.

11. The revised TEFRA limit included a revised Base Amount of $4,027.01 and a revised Adjustment Amount of $6,536.29.

12. On July 19, 1994, the Provider through its attorneys, Goldman, Marshall & Muszynski, P.C., filed a letter with the Intermediary requesting additional adjustment payments due to the distortion of the unit's operating costs pursuant to 42 C.F.R. § 413.40(g)(3).

13. The request was based on another factor which is a basis for a distortion of operating cost adjustment, the increased intensity of service rendered to the unit's patient population.

14. On October 26, 1994, the Provider, through its attorneys, Goldman, Marshall & Muszynski, P.C., filed a letter with the Intermediary supplementing the request and calculating certain additional adjustment payments that were requested.

15. On November 9, 1995, HCFA issued its final decision to the Intermediary regarding the Request. It stated that the Provider ". . . did not file its request for additional adjustment payments for routine and ancillary services within 180 days of the initial November 12, 1993 NPR" and, ". . . the request for additional payments for FYE 1991 is denied."

16. The decision referenced in stipulation 15 was mailed to the Provider on November 15, 1995.

17. On March 14, 1997, the Provider's fiscal Intermediary changed from Ætna to Mutual of Omaha.

18. On May 10, 1996, the Provider requested a hearing at the Provider Reimbursement Review Board ("Board").

19. This request for a hearing at the Provider Reimbursement Review Board was made within 180 days of the date of the former Intermediary's notification letter dated November 15, 1995.

20. Prior to 1995, the text of 42 C.F.R. § 413.40(e) did not specify that an adjustment request must be filed within 180 days of an initial Notice of Program Reimbursement.

21. The documents numbered P-1 - P-16 were submitted by Provider's counsel to the Board as attached to the Provider's List of Documentary. Evidence (both of which are attached hereto) are true and correct copies of the documents described on the said list.

22. Line #2 of HCFA's length of stay adjustment methodology uses a provider's target amount to determine a "per diem limitation."

23. If a provider's target amount changes, line #2 of the length of stay adjustment calculation must be recalculated.

The Provider's filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by R. Christopher Raphely, Esquire, of Goldman, Marshall, Muszynski, PC. The Intermediary was represented by Mr. Tom Bruce of Mutual of Omaha.

PROVIDER'S CONTENTIONS:

The Provider contends that its request for review of its TEFRA exception was timely filed. Either 42 C.F.R. § 413.40(e)(1) or 42 C.F.R. § 413.40(e)(4) provide the basis to find that the Provider's request for additional adjustment payments for its psychiatric unit for FY 91 was timely. The Provider filed the request on July 19, 1994, eighty one days after the Provider received an NPR for FY 91. This NPR was the second NPR the Provider had received for that year and was received on April 29, 1994. Under the plain language of 42 C.F.R. § 413.40(e)(1) as it was in effect at the time the Provider filed the request, the request was timely filed. The plain language of the filing regulation did not distinguish between an initial NPR or any subsequent NPR. Furthermore, by amending the filing regulation after the request was filed to apply only to the initial NPR, HCFA indicated that the language of the filing regulation at the time the request was filed was ambiguous, if not opposite, to the position set forth by the Intermediary. See 42 C.F.R. § 413.40(e)(1).

The Provider argues that the Intermediary's interpretation of the filing regulation to mean that the Provider was limited to filing requests for adjustments within 180 days of its original NPR is contrary to the requirement that an agency promulgate clear and unambiguous regulations.

See Bowles v. Seminole Rock and Sand, Co., 325 U.S. 410 (1954.) Director, Office of Worker's Compensation Program, United States Department of Labor v. Mangifest, 826 F. 2d 1318 (3d Cir. 1987). Therefore, although the costs which were present on the Provider's second NPR were present on the original NPR, the Provider should not be precluded from filing the request within 180 days from the second NPR.

The Provider notes that the Intermediary stated at the Board hearing that 42 C.F.R. § 405.1885 should be used to determine the meaning of the filing regulation.[1] However, upon close examination of 42 C.F.R. § 405.1885, it is clear that this regulation and others that are read in conjunction with it address Intermediary hearings, Board appeals, HCFA Administrator's review and judicial review. They do not address adjustment requests. There is nothing clear or unambiguous in applying a regulation to an issue which it does not address. But, see Care Unit Hospital of Dallas/Fort Worth v. Mutual of Omaha Insurance Company, PRRB Dec. No. 95-D26, Medicare & Medicaid Guide (CCH) ¶ 43,510 ("Care Unit"); Foothill Presbyterian Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, HCFA Adm. 95-D28, Medicare & Medicaid Guide (CCH) ¶ 43,538 ("Foothill"); and Foothill Presbyterian Hospital v. Shalala, No. CV 95-4674 KN, Jan. 2, 1997 (C.D. Cal 1997). Furthermore, even under the regulatory interpretation of the Intermediary, the Provider argues that it filed the request in a timely manner. Unlike the providers in Care Unit and Foothill, the Provider's FY 91 cost report was reopened specifically to recalculate the TEFRA limit for the unit,[2] and the TEFRA limit was adjusted downward resulting in additional cost disallowances which were reflected on the second NPR.[3] As stipulated by the Intermediary and as testified to by the Provider's witness at the hearing on this matter, the Provider notes that this reopening necessarily included two recalculations. The first recalculation was for the unit's base year cost per discharge, updated for inflation. The second recalculation was for an adjustment for the distortion of operating costs that the Provider had been granted on its original NPR.[4] The request directly addressed the calculation of the adjustment amount and the TEFRA limit by asking that they be calculated to take into account a factor which can be considered a distortion of operating cost adjustment, i.e., increased service intensity. Therefore, the request should be considered timely and considered on its merits even if the filing regulation is analyzed in conjunction with 42 C.F.R. § 1885 et seq.

The Provider observes that there are two equally important components that determine a TEFRA Provider's reimbursement, the amount of a Provider's costs and the amount of the Provider's TEFRA limit. An adjustment to a provider's TEFRA limit can effect a Provider's

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1 Transcript ("Tr.") at 14.

2 See Provider Exhibit 2.

3 See Stipulation No. 10.

4 See Stipulations 6-8, and Tr. at 23-27.

reimbursement just as much or more than an adjustment to a provider's costs. Any attempt to decide this case solely on the basis of the fact that no adjustments were made to the Provider's costs on its second NPR, as the Intermediary argues,[5] would ignore the fact that the TEFRA limit is equally important in determining a Provider's reimbursement. That leaves a provider no recourse when its reimbursement is reduced due to an adjustment in the Provider's TEFRA limit. Therefore, the Provider should not be denied the opportunity to request additional adjustment payments when its TEFRA limit and reimbursement are decreased even if its costs remained the same on its second NPR.

The Provider argues that 42 C.F.R. § 413.40(e)(4) specifically grants providers the right to submit additional information and request a review of a decision with respect to an adjustment request no later than 180 days after the date on the intermediary's notice of the decision. In order to decide whether a request by a provider to review a decision regarding an adjustment request was timely under this regulation, one must affirmatively answer two simple questions. First, was a decision regarding an adjustment request made? Second, was a request to review an adjustment made within 180 days of when a decision regarding the request was made? In this case the answer to both questions is clearly yes. The facts of this case are that:

1. The Provider's former Intermediary, Ætna, had initially determined that the Provider was entitled an adjustment for the distortion of operating costs experienced by the unit since its base year based on the increased length of stay experienced on the unit since its base year."[6] and

2. The Provider was notified of its former intermediary's decision to reduce the adjustment amount on April 19, 1994.[7]

Therefore, a decision was made with respect to the Provider's adjustment for the distortion of operating costs on April 19, 1994, and the answer to the first question in the analysis is yes.

In its Position Paper the Intermediary argues that the Provider's request contained an entirely new request for adjustment due to an increased intensity of services.[8] However, the Provider observes that the Intermediary has stipulated to the fact that increased intensity of service is "another factor which is a basis for a distortion of operating cost adjustment."[9] The

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5 Tr. at 14.

6 See Stipulation 4.

7 See Stipulation 5.

8 Intermediary Final Position Paper at 10.

9 See Stipulation 13.

Intermediary also ignores the regulation at 42 C.F.R. § 413.40 (g)(3)(ii) which clearly states that increased length of stay and increased intensity of service are two factors which can be considered as part of one adjustment, an adjustment for the distortion of a Provider's operating costs. Additionally, the Intermediary argues that by incorporating the Provider's adjustment amount into the target amount, the Provider's former intermediary made a mistake which, if it were not made, would make the Provider's argument that the request was timely under § 413.40(e)(4) invalid.[10] However, as the Provider's witness testified that, once the base amount was changed, the Provider's distortion of operating cost adjustment due to an increased length of stay had to be changed.[11] Therefore, whether that adjustment was incorporated into the target amount or not is irrelevant.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the adjustment request dated July 19, 1994, was not filed within the 180 day deadline set by both 42 C.F.R. § 413.40(e)(1) and § 413.40(e)(4). The costs for which the Provider requested an adjustment were not adjusted on the revised NPR; therefore, the Provider cannot use that NPR to extend the time period allotted for its request. In support of its position, the Intermediary cited the reopening regulation at 42 C.F.R. § 405.1885(a). This regulation holds that a determination may be reopened with respect to findings on matters at issue in that detemination or NPR only.[12]

The Intermediary also contends that the Provider has no right to a hearing with respect to its request for an adjustment due to an increase in intensity of services. Appeal rights are limited to matters revised on the NPR as stated in 42 C.F.R. § 405.1889. The Intermediary cites the HCFA Administrator Decision in Care Unit Hospital of Dallas/Fort Worth v. Mutual of Omaha addressed above, in support of this position. Consequently, in the case under appeal, the Provider's appeal rights are limited to the matters revised on the NPR dated April 29, 1994, specifically, the application of the freeze and update factors.[13]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

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[10] Intermediary's Final Position Paper at 3.

[11] Tr. at 23-26.

[12] Tr. 13, 15-25, 14, and 15, 1-6.

[13] Tr. 15, 7-10.

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885	-	Reopening a Determination or Decision
§ 405.1889	-	Effect of a Revision
§ 413.40(e)	-	Hospital Requests Regarding Adjustments to the Payment Allowed Under the Rate-of-Increase Ceiling
§ 413.40(e)(1)	-	Timing of Application
§ 413.40(e)(4)	-	Notification and Review
§ 413.40(g)(3)	-	Comparability of Cost Reporting Periods
§ 413.40(g)(3)(ii)	-	Factors

3. Cases:

Bowles v. Seminole Rock and Sand, Co., 325 U.S. 410 (1954).

Care Unit Hospital of Dallas/Fort Worth v. Mutual of Omaha Insurance Company, PRRB Dec. No. 95-D26, Medicare & Medicaid Guide (CCH) ¶ 43,510.

Director, Office of Worker's Compensation Program, United States Department of Labor v. Mangifest, 826 F. 2d 1318 (3d Cir. 1987).

Foothill Presbyterian Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, HCFA Adm. 95-D28, Medicare & Medicaid Guide (CCH) ¶ 43,538.

Foothill Presbyterian Hospital v. Shalala, No. CV 95-4674 KN, Jan. 2, 1997 (C.D. Cal 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the controlling law, regulations, manual instructions, facts, parties' contentions, evidence submitted and post-hearing briefs finds and concludes that both

42 C.F.R. §§ 405.1889 and 413.40 apply to the facts in this situation. As such, since there were no cost item changes in the revised NPR which was limited to "freeze" and "inflation" factor adjustments, the items in that NPR can only be addressed in the appeal process under 42 C.F.R. § 413.40. Thus, the Intermediary properly applied the above regulations and properly disallowed the Provider's appeal based on an untimely filed appeal request.

DECISION AND ORDER:

The Intermediary properly determined that the Provider's appeal request was untimely made. The Intermediary's determination is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: April 28, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman