PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D77

PROVIDER -All Saints Episcopal Hospital/ Psychiatric Subprovider
Fort Worth, Texas

Provider No. 45-0137

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Texas

DATE OF HEARING-
June 22, 1998

Cost Reporting Period Ended -
September 30, 1987-
September 30, 1989

CASE NO. 94-2804

INDEX

ISSUE:

Was the Health Care Financing Administration's ("HCFA's") denial of the Provider's application for an exception/adjustment to the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") limit for the fiscal years ended ("FYEs") September 30, 1987, 1988 and 1989 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

All Saints Episcopal Hospital ("Provider") is a voluntary nonprofit, general short-term hospital with a 32-bed distinct part psychiatric unit and a 17-bed distinct part rehabilitation unit located in Fort Worth, Texas. The Provider requested an adjustment to its TEFRA limits for the FYEs September 30, 1987 through 1989 for the psychiatric unit. HCFA refused to consider the requests because it determined that the requests were not filed timely. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.
§§ 405.1835-.1841. The Medicare reimbursement effect for all of the years at issue is approximately $486,934.[1]

As a psychiatric facility, the Provider is exempt from the Medicare prospective payment system ("PPS"), and reimbursed in accordance with the cost per discharge limits initially established by TEFRA, P.L. 97-248, 42 U.S.C. § 1395ww(b). Under TEFRA, provider costs are limited by a ceiling on the rate of increase, referred to as the target amount or target rate. The initial target amount is determined by multiplying a provider's allowable Medicare operating cost per discharge in its base year by an applicable target rate percentage. Thus, an adjustment to the base year would effect subsequent year target rate limits ("limits"). TEFRA also established a means by which providers could obtain relief from the limits. See 42 U.S.C. § 1395ww(b)(4)(A) and 42 C.F.R. § 405.463(g) and (h) (redesignation 42 C.F.R. § 413.40(e)).

The Provider received Notices of Program Reimbursement ("NPRs") for FYEs 1987 through 1989, on August 14, 1990, September 30, 1990 and September 30, 1991, respectively. On January 9, 1991, the Provider submitted a letter to Blue Cross and Blue Shield of Texas ("Intermediary") indicating that it would seek an adjustment and/or exception to the limits for all three FYEs.[2] The letter indicates that the request was being made within the 180 days of the NPRs. The letter further indicated that it was the Provider's understanding from its contact with an Intermediary representative that it could submit the supporting documentation at its convenience, and that it hoped to do so within two months.

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1 See Provider Position Paper at 5.

2 See Intermediary Exhibit 1.

On April 14, 1992, the Provider again wrote to the Intermediary and indicated that it planned to submit detailed position papers to support its application for an adjustment and/or exception from the limits.[3] The Provider indicated that it planned to submit its detailed position papers within 90 days and requested that the Intermediary certify that its request had been filed in a timely manner, and that the timing of the submittal of the detailed position papers was acceptable.[4] The Intermediary signed the letter on April 15, 1992, signifying its agreement.[5]

The Provider submitted detailed position papers for FYEs 1987 through 1989 on October 26, 1992, October 29, 1992, and October 19, 1992, respectively.[6] The Intermediary forwarded the Provider's request and supporting documentation to HCFA for FYE 1989 on December 3, 1992.[7] The Intermediary sent the Provider's requests and supporting documentation to HCFA for FYEs 1987 and 1988 on December 11, 1992.[8] The Intermediary agreed with the Provider that adjustments were warranted for fiscal years 1989 and 1987, but did not support an adjustment for 1988.

On February 7, 1994, HCFA denied all of the Provider's adjustment and/or exception requests because they were not filed timely.[9] HCFA noted that the NPRs for FYEs 1987 through 1989 were issued August 14, 1990, September 30, 1990 and September 30, 1991, respectively, but that the adjustment requests were not received until October and November of 1992. HCFA indicated that receipt of the requests was not within 180 days after the date of the NPRs as required by the regulation at 42 C.F.R. § 413.40(e).

On April 22, 1994, within 180 days of HCFA's denial, the Provider appealed to the Board.

The Provider was represented by Manie W. Campbell of CampbellWilson. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

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3 See Intermediary Exhibit 2.

4 Id.

5 Id.

6 See Intermediary Exhibits 3, 4 and 5.

7 Intermediary Exhibit 6.

8 Intermediary Exhibit 7.

9 Intermediary Exhibit 8.

The Provider indicates that HCFA treated its position papers submitted in October and November of 1992 as its application for an adjustment and/or exception to the TEFRA limits. The Provider contends that its January 9, 1991 letter constituted an application for an adjustment and/or exception to the TEFRA limit. According to the Provider, the issue is whether the January 9, 1991 application constitutes an application for an adjustment and/or exception within the meaning of 42 C.F.R. § 413.40(e). The Provider notes that the regulation states that a "hospital may request an exemption from, or exception or adjustment to, the rate of cost increase ceiling imposed under this section." Id. The regulation does not provide any guidance as to what must be included with the "request", and thus did not require that the application be submitted with all supporting documentation and analysis within 180 days of the NPR.

The Provider points out that the regulation was amended on August 30 1991, effective October 1, 1991, to allow providers to submit additional information in support of their application. 42 C.F.R. § 413.40(e) and 56 Fed. Reg. 43196, 43241, (August 30, 1991). The preamble to the regulation indicates that it was HCFA's informal procedure to allow providers to subsequently submit additional information in support of their applications, and that there was no established time limit within which the information had to be submitted. Id. at 43196. Thus, at the time the Provider filed its application, it was HCFA's policy to allow providers to subsequently submit additional information in support of their applications, and there was no established time limit within which the information had to be submitted. The Provider contends that to require a provider to submit all supporting documentation with the application is in direct conflict with this policy.

The Provider also points out that at the time the application was filed there were no instructions in the Provider Reimbursement Manual ("HCFA Pub. 15-1") regarding the elements that had to be included in the application. It was not until August 1994, that HCFA issued instructions regarding the elements that had to be included in the application. These instructions were contained in Transmittal 379, effective August 29, 1994, HCFA Pub. 15-1 § 3000-3006.

The Provider notes that at the time of its application there was no statement in statute, regulation or policy regarding the necessary elements of an application for an adjustment to the TEFRA limit. HCFA's informal policy to permit additional information subsequent to the application also existed at that time. These two pieces of information served as the total guidance for a provider's understanding of the TEFRA limit adjustment process. In its January 9, 1991 application, the Provider stated that it understood from an Intermediary official the it could submit the supporting documentation at its convenience.[10] This was also the Intermediary's understanding of the process, as evidenced by its signing and returning the Provider letter of April 14, 1992, which verified that in the mind of the Intermediary, the application for an exception/adjustment had been filed in a timely manner, and that the

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[10] See Intermediary Exhibit 1.

subsequent submission of the position papers supporting the application was acceptable.[11]

The Provider contends that its January 9, 1991 application complies with 42 C.F.R. § 413.40(e). This regulation merely states that the provider must request an adjustment and/or exception, and the January 9, 1991 application clearly makes that request. The policy in effect at that time, permitted subsequent submission of supporting documentation, which the Provider did in October and November of 1992. Thus, the Provider maintains it complied with the rules in effect at the time, and that its application should be reviewed on its merits.

The Provider notes that if HCFA is allowed to prevail, the Provider will forfeit its right to submit an application, and has no recourse while suffering irreparable harm. The Provider contends that it detrimentally relied on HCFA's policy of allowing a provider to submit the supporting documentation at a later date. If HCFA were going to require that all supporting documentation be submitted with the application, it should have notified the Intermediary and Provider that it had changed its policy. The Provider contends that it is arbitrary and capricious for HCFA to now deny the Provider's request.

The Provider contends that its situation is analogous to that of the provider in Coalinga Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 95-D27, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,223, declined rev. HCFA Administrator, April 24, 1995 ("Coalinga"). In Coalinga, HCFA rejected the provider's's request for an exception to the per visit limit, based upon criteria that were not in the regulation or HCFA Pub. 15-1. The Board held that HCFA improperly denied the provider's request because the criteria relied upon was not in the regulation or instructions. The Board held that due process requires that the criteria be set forth in either the regulation or policy, to provide sufficient notice of the criteria, and lack of such publication results in an unfair burden being placed on the provider. In the instant case, the Provider contends that due process requires that HCFA give notice of any changes in its established procedures, including changes in the application policy for adjustments to the TEFRA limits. The Provider also refers to Providence Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 95-D22, February 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,081, rev'd HCFA Administrator, April 4, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,262, where neither the regulations nor HCFA Pub. 15-1 prescribed what must be submitted with a request to reopen, and thus the provider was not put on notice as to what was required, and could thus submit what it deemed sufficient to support its request.

In summary, the Provider contends that it submitted a timely application in compliance with 42 C.F.R. § 413.40(e) and, in accordance with HCFA policy, it subsequently submitted additional supporting documentation. It was not HCFA's policy to require complete applications within 180 days of the NPR, and HCFA should not be permitted to deny the

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[11] See Intermediary Exhibit 2.

Provider's request on that basis without notice of a change in policy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the Provider asserts that its January 9, 1991 letter was its application, and that no specific rule existed which indicated that an application filed within 180 days could not be supplemented. The Intermediary also acknowledges that the Provider claims that both it and the Intermediary understood that documentation would be subsequently submitted. The Intermediary contends that it understood that there would be subsequent information submitted, but not two years after the Provider's initial notice that it was filing for an adjustment and/or exception. The letter from the Provider indicated that the supplemental information would be coming in two months.

The Intermediary further notes that the Provider referred to the revisions to the regulations that occurred in 56 Fed. Reg. 43196, 43241, (August 30, 1991), which became effective October 1, 1991, that allowed providers 180 days to submit additional information in support of an application. The Provider argues that the informal HCFA policy before the revision was to permit supplemental information without any time limit. The Intermediary disagrees with the Provider's interpretation of this provision. In the discussion referred to by the Provider, id. at 43230, reference is made to HCFA's informal policy regarding submission of additional documentation requested by HCFA in order to reconsider its decision. This would imply that some documentation had been previously submitted and reviewed by HCFA. In the instant case, the Provider did not submit anything other than its intention to file for an adjustment and/or exception to the TEFRA limits on January 9, 1991. The Provider also did not submit anything other than its intention to file in its second letter to the Intermediary on April 14, 1992. The first submission of supporting documentation occurred two years later, on October 1992.

The Intermediary requests that the Board affirm HCFA's denial of the Provider's adjustment requests.

CITATION OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(b)	-	Rate of Increase in Target Amounts for Inpatient Hospital Services

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

§ 405.463(g) and (h)	-	Ceiling on Hospital Cost Increases;

(redesignation § 413.40(e)) Exceptions; Adjustments

§ 405.1835-.1841 - Board Jurisdiction

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 3000 et seq. - Hospitals and Distinct Part Units of Hospitals Excluded from Prospective Payment System

4. Cases:

Coalinga Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 95-D27, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,223, declined rev. HCFA Administrator, April 24, 1995.

Pioneers Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 92-D33, May 1, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,207, declined rev. HCFA Administrator, June 12, 1992.

Providence Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 95-D22, February 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,081, rev'd HCFA Administrator, April 4, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,262.

5. Other:

56 Fed. Reg. 43196, 43241, (August 30, 1991).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Board notes that the regulations require that a provider request an adjustment and/or exception within 180 days of the NPR. 42 C.F.R. § 413.40(e). The regulation in effect at the time of this case did not indicate what had to be included with the request. There were also no manual provisions in effect at that time that addressed this issue. The Board finds that the Provider's January 9, 1991 request for an adjustment and/or exception met the regulatory requirement of being submitted within 180 days of the NPR.

The Board notes that the Provider's January 9, 1991 request indicated that the Provider had contacted the Intermediary and that both parties understood that supporting documentation could be submitted at a later date.[12] The Board further notes that Provider did not submit the supporting documentation within the two months, as planned. In fact, on April 14, 1992, over one year later, the Provider submitted a letter to the Intermediary indicating that it was still developing its detailed position paper to justify the requests.[13] The Provider's letter sought reassurance from the Intermediary that its adjustment and/or exception request was timely, and its later submission of detailed position papers would be acceptable. The Intermediary signed and returned the letter to the Provider concurring with that inent.

In HCFA's letter denying the Provider request, it treats the Provider's detailed position papers, dated in October of 1992, as the Provider's requests for adjustment and/or exception, and finds that since the detailed position papers were not received within 180 days of the respective NPRs, the Provider requests were not filed timely.[14] The Board finds, however, that it was not until 1994 that HCFA established detailed requirements for what had to be submitted with a request for an adjustment and/or exception. The Board has previously held that a provider must comply with specific requirements in the manual for ESRD exception requests or have the Intermediary's rejection of its request affirmed. See Pioneers Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Case No. 92-D33, May 1, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,207, declined rev. HCFA Administrator, June 12, 1992. In the instant case, however, the Board finds that there were no detailed instructions concerning the requirements for a complete request in existence, and therefore, the Provider's January 9, 1991 request was sufficient to meet the regulatory requirement of being submitted within 180 days of the NPR. Since the requests were timely, the Board finds that HCFA should review them on their merits.

DECISION AND ORDER:

The HCFA determination that the Provider's TEFRA requests were untimely was incorrect. The Board remands the Provider's TEFRA requests to HCFA for review on their merits.

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12 See Intermediary Exhibit 1.

13 See Intermediary Exhibit 2.

14 See Intermediary Exhibit 8.

Board Members Participating:

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

Date of Decision: July 27, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman