PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D39

PROVIDER –
Hemet Valley Convalescent Hospital
Hemet, California

Provider No. 55-5405

vs.

INTERMEDIARY –
United Government Services, LLC –CA/
Blue Cross Blue Shield Association

DATE OF HEARING -
May 22, 2003

Cost Reporting Period Ended
December 31, 1994

CASE NO. 97-2608

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ISSUE:

Was the Intermediary's denial of the Provider's SNF routine service cost limit exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hemet Valley Convalescent Hospital ("Provider") is a for-profit, skilled nursing facility ("SNF") located in Hemet, California. On August 30, 1996, Blue Cross of California ("Intermediary") issued a Notice of Program Reimbursement ("NPR") perfecting final settlement of the Provider's cost report for its reporting period ended December 31, 1994. In a letter to the Intermediary dated February 26, 1997, the Provider requested an exception to Medicare's routine service cost limits on the basis that it furnished atypical services.

Although the Provider's letter requesting an exception to the cost limits was dated February 26, 1997, it was not received by the Intermediary until February 27, 1997, or 181 days from the date of the applicable NPR. Therefore, on March 27, 1997, the Intermediary notified the Provider that its request had been denied on the basis that it was not filed timely pursuant to 42 C.F.R. § 413.30(c), which establishes a 180-day time limit for the submission of such requests.

The Provider contends that its request was submitted late due to circumstances beyond its control. The Provider explains that it sold its facility on May 1, 1996, prior to the issuance of the pertinent NPR, and that all of the facility's financial records remained with the new owner. In October 1996, the Provider began to request certain information from the new owner that was needed to complete the exception request. However, it was not until mid-January 1997, that the Provider realized the new owner would not furnish the information, and it became necessary for the Provider to hire outside sources to visit the facility for that purpose.[1]

The Intermediary relies upon 42 C.F.R. § 413.30(c) to support its position. In pertinent part, the regulation states:

> [t]he provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to HCFA, which makes the decision.

42 C.F.R. § 413.30(c).

On July 18, 1997, the Provider appealed the Intermediary's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare

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[1] Provider Position Paper at 2. Exhibit P-4.

funds in controversy is approximately $48,790. The Provider was represented by William A. Fretwell, Vice President, Hospital Management Services. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.[2]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and policies, parties' contentions and evidence presented, finds and concludes that the Intermediary properly denied the Provider's request for an exception to Medicare's routine service cost limits.

The Provider hand-delivered its request to the Intermediary on February 27, 1997, which is 181 days after the date of the pertinent NPR. The Provider explained that it was unable to submit its request any sooner than February 27th due to circumstances beyond its control.

Medicare regulations addressing this matter are found at 42 C.F.R. § 413.30(c). In part, these regulations state: "[t]he provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement." Id. The regulations contain no provision for the submission of an exception request beyond the 180-day limit.

The Board is bound by Medicare statutes and regulations and, with respect to the instant case, the controlling authority at 42 C.F.R. § 413.30(c) is clear. Accordingly, the Provider's failure to submit its request within the 180-day requirement must result in the request's denial.

DECISION AND ORDER:

The Intermediary properly denied the Provider's request for an exception to Medicare's routine service cost limits. The Intermediary's denial is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell

Date: July 18, 2003

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[2] Intermediary Position Paper at 4. Provider Position Paper at 1.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman