PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D40

PROVIDER –
Citrus Health and Rehabilitation Center
Inverness, Florida

Provider No. 10-5858

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
December 4, 2002

Cost Reporting Periods Ended
May 31, 1996, 1997 and 1998

CASE NO. 01-2787

INDEX

ISSUE:

Did the Centers for Medicare and Medicaid Services ("CMS")[1] properly deny the Provider's request for an exemption from the Medicare skilled nursing facility routine service cost limits ("SNF RCLs") as a new provider under 42 C.F.R. § 413.30(e) based on CMS' determination that the exemption request was not timely filed for cost reporting periods ended May 31, 1996, 1997 and 1998?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Citrus Health and Rehabilitation Center ("Provider") is a skilled nursing facility ("SNF") located in Inverness, Florida. For the fiscal year ended ("FYE") May 31, 1996, Mutual of Omaha Insurance Company ("Intermediary") allowed the Provider an exemption from the SNF RCLs after noticing that Aetna Life Insurance Company ("Aetna"), the Provider's former intermediary, recognized an exemption for the 1995 cost reporting period. However, the record shows that Aetna failed to seek CMS' approval, as required by the exemption process, and erroneously authorized the exemption to the Provider. The Intermediary discovered this error when it denied the Provider's reopening request for an exemption for FYEs May 31, 1997 and 1998 due to a lack of documentation.

In light of the prior errors, the Intermediary attempted to rectify this situation by forwarding to CMS the Provider's exemption request dated January 6, 1995.[2] Based on the information attached to its forwarding letter, the Intermediary advised CMS that the Provider met the definition of a new facility at the time the request was filed. Accordingly, the Intermediary recommended an exemption to the RCLs for fiscal years ended May 31, 1995 through May 31, 1998.[3] In response, CMS asked that the Provider refile its request and advised the Intermediary to recover the previously allowed exemption amounts in case the exemption was denied. While the cost report for FYE May 31, 1996 was reopened and revised, the cost report for FYE May 31, 1995 was beyond the three-year reopening period and could not be revised.

In response to CMS' request, the Provider filed a formal request on June 18, 2000, and subsequently complied with CMS' request for submission of additional documentation to support the exemption request.[4] By letter dated September 19, 2000, CMS notified the Intermediary that the Provider's exemption request was denied due to untimely filing (i.e., the request exceeded the 180-day filing window following the dates of the respective Notices of Program Reimbursement ("NPRs").[5] Upon being notified by the Intermediary of CMS' determination, the Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") on March 30, 2001.[6]

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[1] CMS was known as the Health Care Financing Administration ("HCFA") at the time denial actions were taken. This decision will refer to the name of the agency as CMS unless otherwise required by context.
[2] See Intermediary's Exhibit I-1.
[3] See Intermediary's Exhibit I-3.
[4] See Intermediary's Exhibit s I-4 through I-8
[5] See Intermediary's Exhibit I-9.
[6] See Provider's Exhibit A to Final Position Paper.

In a letter to the Board dated August 14, 2001, the Intermediary advised of a jurisdictional impediment with respect to the Provider's inclusion of the FYE May 31, 1995 in its appeal request. Inasmuch as the previous intermediary, Aetna, had allowed an exemption for that year which was beyond the three-year reopening period, the Intermediary questioned the Board's jurisdiction given the fact that the exemption was recognized. At the commencement of the hearing before the Board, the parties came to an agreement that FYE May 31, 1995 was not an issue before the Board, but that the information pertaining to that year would be relevant for the remaining years appealed by the Provider.[7]

Subsequent to the hearing before the Board, the Intermediary again raised the question of jurisdiction as an additional argument in its post-hearing brief. The Intermediary argued that the Provider had failed to timely complete its exemption request for FYE May 31, 1995 and, thus, did not receive a final determination by CMS on the substantive merits of the exemption request for the remaining years in contention. While the Board may review a final determination by CMS, it may not make the initial determination with regard to the exemption request or the timeliness of the application. By failing to exhaust its administrative remedy, the Intermediary concludes that the Provider does not have a final agency determination which is the threshold requirement necessary for Board jurisdiction under the provisions of 42 C.F.R. §§ 405.1835-405.1841.

In response to the jurisdiction issue raised by the Intermediary, the Provider submitted to the Board a "Motion to Strike and Disregard New Issue Raised by Intermediary." The Provider argued that neither CMS nor the Intermediary have ever argued, submitted correspondence or documentation, or testified that the Provider was not entitled to a hearing due to a lack of a final determination. Moreover, the raising of a new issue subsequent to the Board hearing is not only prejudicial and untimely, it is also contrary to Board instructions which state that "[p]ost-hearing briefs are ***not*** to be utilized to submit new evidence or make new arguments." Contrary to the Intermediary's contention, the Provider asserts that the regulatory provisions of 42 C.F.R. §§ 405.1835-405.1841 clearly authorize the appeal in the instant case.

In response to the jurisdiction issue raised by the Intermediary, the Board finds that the Provider filed a proper hearing request on March 30, 2001, which appealed HCFA's final determination denying the Provider's request for a new provider exemption from the Medicare SNF RCLs for the Provider's first four fiscal years of operation under the Medicare program. By letter dated September 19, 2000, HCFA notified the Intermediary that the Provider's new provider exemption request had been denied for the cost reporting years ended May 31, 1995, 1996, 1997 and 1998 because the request was not filed within 180 days of the date on the Intermediary's NPRs.[8] In turn, the Intermediary informed the Provider on October 3, 2000 of HCFA's determination and advised the Provider that it was entitled to file a formal appeal with the Board in accordance with 42 C.F.R. §405.1801 et.seq. if it disagreed with HCFA's final determination.[9] The Board finds that the Provider filed a proper and timely appeal request for the cost reporting periods in contention and has

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[7] Tr. at 9-17.
[8] See Intermediary's Exhibit I-9.
[9] See Intermediary's Exhibit I-10.

fully met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The estimated amount of Medicare reimbursement in controversy is approximately $730,000. The Provider was represented by Alfred W. Clark, Attorney at Law. The Intermediary's representative was Byron Lamprecht of the Mutual of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS improperly denied its exemption request on the basis that it was not timely filed under the governing regulations. The Provider asserts that it submitted its request to the Intermediary by overnight courier on January 6, 1995, and on two subsequent occasions; all of which were within the 180-day deadline prescribed by 42 C.F.R. § 413.30(c) and the manual provisions set forth under §2531.1A of the Provider Reimbursement Manual ("CMS Pub. 15-1").[10] In addition to the substantial uncontradicted evidence filed with the Intermediary and the sworn testimony of the Provider's representative who personally prepared and submitted the request to the Intermediary, the Provider notes that it was, in fact, reimbursed consistent with an approved request for exemption for FYEs May 31, 1995 and 1996. Moreover, the Intermediary admitted in correspondence to HCFA that the request had been submitted in 1995, but the prior intermediary had failed to forward the request to HCFA as required.[11]

In addition to denying the request based on untimely filing, CMS also contended that the January 6, 1995 submission by the Provider was not a "proper" request because of its form and language (i.e., it did not specifically state "We request an exemption.") The Provider contends that any person reviewing its submission would recognize it to be a request for exemption. The request, together with additional documentation, was submitted with a cover memorandum that contained a reference line that stated – "Request for Cost Limitation Exemption." The memorandum was addressed to the Intermediary's Audit and Reimbursement Division and specifically requested assistance in obtaining an exemption under the new provider guideline.[12] The Provider asserts that the intent of its submission was abundantly clear and complied with the requirements set forth under 42 C.F.R. §413.30(c) and CMS Pub. 15-1 § 2531.1A. Moreover, the Intermediary recognized it as an exemption request and recommended that the Provider be granted its request for FYEs May 31, 1995 through May 31, 1998.

With respect to CMS' contention that the Provider's request was not submitted until July 18, 2000, the Provider argues that this determination was based upon a subsequent memorandum that was submitted in accordance with specific instructions specified by HCFA.[13] The Provider notes that HCFA did not initially reject the request as being untimely, rather, HCFA requested additional information which the Provider furnished to the Intermediary. Upon review of this additional information, the Intermediary again recommended approval of the exemption request.

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[10] See Provider's Exhibit P-38 – History and New Provider Exemption Request Timeline.
[11] See Provider Exhibit P-26.
[12] See Provider's Exhibit P-5.
[13] See Provider's Exhibit P-27

The Provider is unclear as to the reason CMS raised the issue of whether the year-end of April 30 or May 31 should have been used, or why the reference to an incorrect year-end would have any impact on an exemption request. Although an April 30 year end was initially selected, the Provider asserts that the record clearly documents that appropriate authorities, including the Intermediary, were notified of the requested change to a May 31 year-end. The requested change in fiscal year-end was caused by the delay in the opening of the facility. Further, the May 31 year-end has been consistently used by all parties for cost reporting and audit functions and complies with the requirements of 42 C.F.R. §413.24(f)(3).

Finally, the Provider contends that there is no law, regulation or program instruction which requires a provider to submit a separately identifiable request for exemption for each cost reporting period for which an exemption is sought. Moreover, the regulation at 42 C.F.R. § 413.30(e) clearly establishes that an approved exemption may apply to multiple cost reporting periods as follows:

> An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

42 C.F.R. § 413.30(e).

The Intermediary had no difficulty in applying the request in accordance with the regulation when it recommended approval of the single request for multiple years in its letter of April 27, 2000,[14] which stated:

> The Code of Federal Regulations § 413.30(e) allows a granted exemption to remain in effect for two years after the provider accepts its first patient. This facility accepted its first patient on July 7, 1994. Hence, this facility would be entitled for an exemption, if granted, through the cost report period ended May 31, 1998.

Additionally, the Provider points out that it has been reimbursed consistent with an approved exemption for more than one year based upon a single request. Contrary to CMS' position, the Provider insists that there is no requirement in the regulations or manual instructions which implies that an exemption request must specify all cost reporting periods to which the request applies. In summary, the Provider recommends that the Board remand its properly filed exemption request to CMS for review and determination on the merits.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that CMS' denial of the Provider's exemption request was consistent with the requirements set forth in 42 C.F.R. § 413.130 and Chapter 25 of CMS

[14] See Provider's Exhibit P-26.

Pub. 15-1. Pursuant to 42 C.F.R. § 413.130(c), a provider's request must be made to its fiscal intermediary within 180 days of the date on the Intermediary's NPR. The requirements of the regulation are further explained under CMS Pub. 15-1 §2531.1A which includes the following:

1. A written request must be filed with the intermediary;

2. The request may be filed prior to the beginning of, during, or after the close of the affected cost reporting period. However, the request must be filed with the intermediary no later than 180 days from the date of the intermediary's notice of program reimbursement (NPR). If the request is filed more than 180 days after the date on the notice of program reimbursement, the provider is not eligible for an exception or exemption for that cost reporting year;

3. The type of request must be specified, i.e., exemption, or exception; and

4. The request must include all supporting documentation for each type of request as described in subsequent subsections. With regard to exemption requests, this documentation is spelled out in CMS Pub. 15-1, Section 2533.1(D)(2).

The Intermediary contends that the Provider's exemption request, dated July 18, 2000, exceeded the 180-day filing window following the date of the NPRs which resulted in the denial determination. The Intermediary further maintains that the Provider's memorandum, dated January 6, 1995, is not a proper and/or acceptable request for exemption under the requirements set forth in the established program policy. On its face, the memorandum does not present the appearance of a request as there is no language which specifies a "request" is being made or the time period for which the request is being sought. The Intermediary further notes that no citation or reference is made to the applicable program policy, and there was no signature attesting to the validity of the data submitted.

While the Intermediary acknowledges that the subject line of the January 6, 1995 memorandum states – "REQUEST FOR COST LIMITATION EXEMPTION," the Intermediary believes the correspondence is merely a submission of additional information on the matter at the request of Aetna. However, whether the memorandum is a follow-up to an earlier verbal or written exemption request has not been substantiated by the Provider. The Intermediary alternatively argues that, if the Board accepts the January 6, 1995 memorandum as a proper exemption request, then the Provider's relief from the cost limits should be confined to the FYE May 31, 1995. Since the alleged request was void of any specific time frame or FYEs, the application should be limited to only the first year of operation. The Intermediary asserts that an exemption is not automatically applied to subsequent cost reporting periods because the limits are

established on a "year-by-year basis" and potential exemption requests are to be filed on the "affected cost reporting period."

FINDINGS OF FACTS, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions, and testimony and documents submitted into evidence, finds and concludes that the Provider filed a proper and timely new provider exemption request pursuant to the requirements set forth under 42 C.F.R. § 413.30(c) and CMS Pub. 15-1 §2531.1A.

The Board finds that there is substantial and uncontradicted evidence in the record that the Provider filed an exemption request with its Intermediary on January 6, 1995. At the hearing before Board, the Provider's representative and sworn witness testified that she personally prepared and placed the request in Federal Express to the Intermediary in 1995, personally faxed the request to the Intermediary in 1996, and personally hand delivered the request again to the Intermediary in 1997.[15] The record further shows that the Provider's representative sent a substantial package to the Intermediary's contact person on the date of the Provider's original request for exemption,[16] and that the Provider's new Intermediary admitted in correspondence to HCFA that the request had been submitted in1995 but not forwarded to HCFA by the prior Intermediary.[17] The Board also notes that the person who prepared and submitted the request had extensive experience in submitting requests and certification documents to the Intermediary, including cost reports, new provider documentation, and requests for exemption. The most convincing evidence of the Provider's timely submission of an exemption request is the fact that both the prior Intermediary (Aetna) and the current Intermediary (Mutual) reimbursed the Provider consistent with an approved request for exemption for its first two cost reporting periods.

While the record is devoid of any documentation relating to the actions taken by the Intermediary or HCFA in processing the Provider's original exemption request, the Board finds that the Provider fully complied with the application requirements set forth in the regulations and guidelines, and that the Provider caused none of the deficiencies that later materialized during the review and decision-making process. It is the Board's belief that: (1) either the Intermediary granted the Provider's exemption request without CMS' approval; or (2) the records associated with the approval process were lost. Under either scenario, the subsequent actions taken by the Intermediary and CMS which led to the necessity of the Provider appealing this matter to Board can only be classified as arbitrary and capricious.

The Board finds that it was disingenuous on the part of CMS to ask the Provider to refile its exemption request in June of 2000 and subsequently deny that request on the basis that it was not timely submitted. This egregious action, combined with the superfluous arguments subsequently raised with respect to the propriety of the original exemption

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[15] Tr. at 44-47; 64-65; and 78-80.
[16] See Provider's Exhibit P-35.
[17] See Provider's Exhibit P-26.

request, do not diminish the fact that the Provider filed a timely and proper exemption request on January 6, 1995. The post-positional arguments raised by the Intermediary and CMS to bolster the prior denial determination are not supportable under the factual evidence presented or the proper application of the Medicare regulations and guidelines.

The record shows that the Provider's request was submitted with a cover memorandum and additional documentation that included a questionnaire which was required by the Intermediary. The cover memorandum contained as a reference line "Request for Cost Limitation Exemption." It was addressed to the manager of the Intermediary's audit and reimbursement division and specifically requested assistance in obtaining the exemption. While it is CMS' contention that the January 6, 1995 submission was not a proper request because of its form and language, the Board finds the Provider's submission to be an unambiguous request for an exemption from the SNF RCLs. Moreover, the statement "Request for Exemption" is specifically included in the heading on each page of the questionnaire attached to the memorandum. The Board further notes that both Intermediaries understood that the memorandum, with its attachments, was an exemption request for the cost reporting years in question. Neither the regulation at 42 C.F.R. §413.30(c) nor CMS Pub. 15-1 §2531.1A prescribes the form which a request must follow or the language it must contain.

With respect to the Intermediary's and CMS' contention that a separate indentifiable request for exemption must be submitted for each cost reporting period for which an exemption is sought, the Board finds that the regulatory provisions of 42 C.F.R. §413.30(e) clearly support the multiple-year request submitted by the Provider. The regulation states in part:

> An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

The regulation contains no language which expressly or implicitly requires a provider to submit separate requests for each cost reporting period within the limits of expiration of the exemption. If the Board were to accept CMS' interpretation of the regulation, the language of 42 C.F.R. § 413.30(e) would be meaningless.

In denying the Provider's exemption request, CMS inexplicably raised the issue of whether the fiscal-year end of April 30 or May 31 should have been used by the Provider. While the Board finds that this matter has no relevancy to the process of granting an exemption, it is equally clear that the May 31 year-end has been consistently used by the Provider and the Intermediary throughout all cost reporting periods in contention.

DECISION AND ORDER:

CMS improperly denied the Provider's request for an exemption from the Medicare SNF RCLs as a new provider under 42 C.F.R. § 413.30(e) based on its determination that the

request was not timely filed for cost reporting periods ended May 31, 1996, 1997 and 1998. The Provider's exemption request is remanded for review and determination on the merits.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, DDS
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

DATE: July 29, 2003

FOR THE BOARD

Suzanne Cochran
Chairman