# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D12

**PROVIDER** –
NYCHHC 94 TEFRA Target Amt.
Per Case E/E Group

Provider Nos.: See Appendix

**vs.**

**INTERMEDIARY –**
Blue Cross Blue Shield Association/
Empire Medical Services

**DATE OF HEARING -**
August 24, 2004

Cost Reporting Period Ended -
June 30, 1994

**CASE NO.**: 99-0452G

**INDEX**

ISSUE:

Whether the Intermediary properly processed the Providers' TEFRA exception request.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20(b) and 413.24(b).

From the Medicare program's inception in 1966 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1); see generally Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993). The statute at 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . ." Congress ultimately amended the reasonable cost payment system because it was concerned that, while being reimbursed the reasonable costs of covered services, providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs and authorized the Secretary of the Department of Health and Human Services (Secretary) to promulgate regulations to establish prospective limits on the costs recognized as reasonable in furnishing patient care. One of the regulations the Secretary promulgated to provide such limits on cost reimbursement was 42 C.F.R. §413.30.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses, including capital and medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a

provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year. However, the regulation implementing TEFRA, 42 C.F.R. §413.40, establishes the procedure and criteria for providers to make requests to CMS for exemptions and adjustments to the rate-of-increase ceiling amount.

In 1983, Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit. In this case, the Provider's inpatient psychiatric, rehabilitation, and chronic care units continue to be subject to TEFRA and its rate-of-increase limit.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

New York City Health and Hospitals Corporation (Provider) operates the municipal hospital system of the City of New York. The system's acute care hospitals annually provide more than a million days of inpatient care, and its outpatient clinics had over 5.5 million visits in fiscal 1998.

On February 19, 1998, the Provider filed a request for relief from the TEFRA target limits for its fiscal year ended 6/30/94. The request was based upon considerations of average length of stay (ALOS) for the 20 providers included in this group and involved approximately $13.1 million of Medicare reimbursement.

Empire Health Services (Intermediary) determined that the request was incomplete and, consequently, requested additional information from the Provider on March 11, 1998. The Provider did not respond and the Intermediary subsequently closed the Provider's exception request on May 5, 1998.

The parties concur that the regulations at 42 C.F.R. §413.40 and the instructions at Provider Reimbursement Manual (PRM) 15-1, §3004 are controlling. Further, there is no dispute that the Provider's exception request was incomplete. Rather, the dispute in this case centers on the authority of the Intermediary to close the request and the propriety of that closing as a denial determination.

PARTIES' CONTENTIONS:

The Provider contends that neither the regulations nor the PRM authorize the Intermediary to close an exception request. The Provider asserts that 42 C.F.R. §413.40(e) authorizes the fiscal intermediary to examine a request for exception and make a decision, if authorized, or, alternatively, recommend a decision and refer the matter to CMS for a decision. The Provider argues that, by closing the request, the Intermediary did neither. The Provider argues further that PRM 15-1, §3004.3 merely permits an intermediary to establish a deadline and then forward the request to CMS or make a decision on the merits. It does not authorize an intermediary to close the request

if a provider fails to respond by the deadline. Rather, the section requires that where the hospital has not responded within the deadline, the intermediary either forwards the application with its recommendation to CMS or, if authorized, makes a decision on the basis of the information that it has received. The Provider asserts that CMS has not authorized the Intermediary to make a decision in this case, nor has the Intermediary decided the case or made a recommendation for CMS's final determination.

The Provider also notes that 42 C.F.R. 413.40(e)(4) contemplates that a provider may initially fail to submit sufficient information to support its request and it authorizes the provider to submit additional information after a decision by CMS. The regulations state that the CMS decision is considered final unless the hospital submits additional information and requests a review of the decision no later than 180 days after the date on the intermediary's notice of the decision. The Provider asserts that its right to submit additional documentation after a final decision was foreclosed by the Intermediary's unauthorized closing of the request.

The Intermediary contends that the instructions contained at PRM 15-1, §3004.3 and in guidance from the New York Regional Office dated February 21, 1996, specifically authorizes intermediaries to decide exception requests where, as here, the request is based upon ALOS. Using this authorization, the Intermediary closed the case and argues that the closure constitutes a final decision based upon the merits of the application.

The Intermediary also disputes the Provider's assertion that the closure impeded its right to submit additional information after a final decision was issued. The Intermediary argues that under PRM 15-1, §3004.5, a provider may request a review of an intermediary's determination by submitting a review request and additional information within 180 days of the intermediary's closure/denial notice. The Intermediary asserts that the Provider made no attempt to request such a review after it received the Intermediary's closure notice.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board's examination of the controlling regulations and PRM instructions indicated that both are presented in sufficient detail and with sufficient clarity that the dispute offered for our consideration could have been avoided by a more disciplined adherence to their respective requirements by both parties. Nevertheless, the pivotal issue for the Board's considerations remains the propriety and effect of the Intermediary's closure as a final determination on the Provider's application.

The Board recognizes that the Intermediary's closure notice operated as a functional denial determination. However, the notice did not meet the standards for a denial determination set in PRM 15-1, §3004.3 and §3004.4. The notice did not include a definite statement that it was a final determination based upon a review on the merits of the application. In addition, the notice did not advise the Provider of its appeal rights, nor was a copy provided to CMS. Further, the notice was ambiguous and offered the Provider no instructions or guidance as to any recourse. The Board acknowledges that

the deficiencies in the notice were exacerbated by the Provider's failure to respond or solicit advice from the Intermediary once it received the notice. However, the collective deficiencies of the closure notice compel the Board to conclude that it was a defective determination that does not satisfy the standards for a proper denial determination set by PRM 15-1.

Accordingly, the Board finds that the Intermediary's closure of the Provider's request for an exception to the TEFRA limits does not constitute a final denial determination on the merits of the application. The Board finds further that such a determination is necessary to allow the Provider to access the remedies available under 42 C.F.R. §413.40. Consequently, the Board remands the Provider's request for an exception to the TEFRA limits to the Intermediary for a final determination on the merits of the application.

DECISION AND ORDER:

The Intermediary's closure of the Provider's request for exception to the TEFRA limits does not constitute a final denial determination on the merits of the application.

The Board hereby remands the Provider's request for an exception to the TEFRA limits to the Intermediary for a final determination on the merits of the application. The Board directs that the determination be conducted in accordance with the instructions at PRM 15-1, §3004.3 and that notice of the resultant determination be provided to the Provider in a format that satisfies the standards articulated at PRM 15-1, §3004.4. That notice should include an explanation of the determination based upon the merits of the application as well as a notice of the Provider's appeal rights, including its right to appeal the determination within 180 days.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: December 17, 2004

Suzanne Cochran, Esq.
Chairman

APPENDIX

| Provider Name | Type | Provider Number |
|---|---|---|
| Bellevue Hospital Center | Rehab | 33-T204 |
| Bird S. Coler Memorial Hospital | Long Term | 33-2016 |
| Coney Island Hospital | Psych | 33-S196 |
| Coney Island Hospital | Rehab | 33-T196 |
| Elmhurst Hospital Center | Psych | 33-S128 |
| Elmhurst Hospital Center | Rehab | 33-T128 |
| Goldwater Memorial Hospital | Long Term | 33-2008 |
| Harlem Hospital Center | Rehab | 33-T240 |
| Jacobi Medical Center | Psych | 33-S127 |
| Jacobi Medical Center | Rehab | 33-T127 |
| Kings County Hospital Center | Psych | 33-S202 |
| Kings County Hospital Center | Rehab | 33-T202 |
| Lincoln Med & Mental Health Center | Psych | 33-S080 |
| Metropolitan Hospital Center | Psych | 33-S199 |
| Metropolitan Hospital Center | Rehab | 33-T199 |
| North Central Bronx Hospital | Psych | 33-T385 |
| Queens Hospital Center | Psych | 33-S231 |
| Queens Hospital Center | Rehab | 33-T231 |
| Woodhull Med. & Mental Hlth. Center | Psych | 33-S396 |
| Woodhull Med. & Mental Hlth. Center | Rehab | 33-T396 |