PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D72

PROVIDER –
Saddleback Memorial Medical Center
Laguna Hills, California

Provider No.: 05-0603

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC-CA

DATE OF HEARING –
April 18, 2005

Cost Reporting Period Ended -
June 30, 1996

CASE No. : 99-2472

INDEX

ISSUE:

Whether CMS' denial of the Provider's request for a new provider exemption based upon a finding of an untimely submission in response to a request for additional documentation was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the 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).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Saddleback Memorial Medical Center (Provider) is a general acute care hospital located in Laguna Hills, California. The Provider was certified to participate in the Medicare program as a skilled nursing facility (SNF) on September 14, 1995 with a total of 18 beds. The Provider claimed costs for the SNF on its fiscal year ended (FYE) June 30, 1996 cost report as a new provider exempt from the routine cost limits (RCL). United Government Services (Intermediary) issued a Notice of Program Reimbursement on September 30, 1998, in which it applied the SNF RCL to the Provider's costs, as the Provider had not been approved for a new provider exemption. Subsequently, on March 29, 1999 the Provider applied for the new provider exemption to the RCL for its skilled nursing facility.

The Intermediary reviewed the documents submitted by the Provider and forwarded the request to CMS for a final determination. After reviewing the Provider's request and documentation, in a letter dated September 23, 1999, CMS stated that the Provider had failed to support its request to be exempt from the SNF RCL because of lack of documentation. CMS directed the Intermediary to request the additional documentation from the Provider.

In a letter dated October 20, 1999, the Intermediary notified the Provider of the request for additional documentation. The letter stated, in part, "[T]he provider has 45 days from the date of this notification letter to submit a new exemption request with all the documentation requested. Submission after 45 days will be treated as non-timely filed and will be denied."

On Monday, December 6, 1999 the Provider submitted its request for an exemption to the RCL to the Intermediary via facsimile, Federal Express and certified U.S. mail. The facsimile was received by the Intermediary on December 6th, the Federal Express package on December 7th, and the certified mail copy on December 8th, 1999.

CMS responded in an April 2, 2000 letter stating,[1] "The intermediary advised Saddleback on October 20, 1999 that it had submitted an incomplete exemption request and that it had 45 days from October 20, 1999 to submit a complete request. Saddleback has failed to submit a complete exemption request within 45 days of the date it was notified by the intermediary. Therefore, Saddleback's request for an exemption is denied." The Intermediary then notified the Provider of CMS' denial in an April 27, 2000 letter stating: "This is to notify you of [CMS'] determination per their April 2, 2000 letter enclosed, which denies the subject request due to late receipt of supplemental information."

The estimated amount of Medicare reimbursement withheld as a result of this adjustment is $964,000.

The Provider timely appealed the RCL adjustment to the Board and met the jurisdictional requirements of 42 C.F.R §§ 405.1835- 405.1841. The Provider was represented by David L. Volk, Esquire, of Sonnenschein Nath & Rosenthal, LLP. The Intermediary was represented by Bernard Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary argues that the "starting point" for its 45-day count begins by counting the date stamped in its letter to the Provider, October 20, 1999, as the first day. Counting 45 days from that date, the Intermediary contends that the Provider's request was due Friday, December 3, 1999.

In the alternative, the Intermediary argues that if the "starting point" is the day after the date stamped on its denial letter, the Provider's request was due on Saturday, December 4, 1999. Even if the due date fell on a Saturday, it was the Provider's responsibility to submit its request by that date.

The Provider argues that universally accepted calendaring methods apply, under which the date of an event is not counted, and a final day that occurs on a weekend is rolled over to the first business day thereafter. The Provider also asserts that this calendaring method is consistent with

[1] The Intermediary's position is that the sole basis for denial was the untimely submission of the December 6, 1999 Provider response, and that there has not yet been a CMS decision on the substantive response contained in the Provider's submission.

the Medicare statute, the Federal Rules of Civil Procedure, Medicare regulations, proposed appeal rules applicable to the PPRB, Administrator decisions and recent PRRB decisions[2].

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence and the parties' contentions, finds and concludes as follows:

The Intermediary did not cite any authority for its position that the date of an event, such as the date stamped on its denial letter, is counted as the first day of a calendar count. It is common practice that the day following the date of notice is the "starting point" for a deadline, a practice that is followed by the Administrator as well as the Board. See Rush-Presbyterian – St. Luke's Medical Center v. Blue Cross and Blue Shield Association/Adminastar Federal, Inc., HCFA Administrator Decision, CCH ¶80,643 (Jan 2, 2001); Maria Manor Nursing Care Center (St. Petersburg, Fla.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, CCH ¶45,265 (May 26, 1997). This practice is also consistent with other regulations applicable to the Medicare program. For example, 42 C.F.R., §1005.12, "Computation of time" for appeals of exclusions and civil penalties states:

> (a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event or default, and includes the last day of the period unless it is a Saturday, Sunday or legal holiday observed by the Federal Government, in which event it includes the next business day.

Also, proposed rules for PRRB appeals follow this day count methodology. 65 Fed. Reg. 35716, Proposed Rules (June 25, 2004). Proposed regulation section 405.1801(d)(1) states that: "[t]he day of the act, event, or default from which the designated time period begins to run is not included." 65 Fed. Reg. at 35745. The preamble to the proposed rules states: "[a]s to the first day of such a period, the day of the act, event or default from which the designated time period begins to run would be excluded from the period." 65 FR at 35720.

This counting methodology is also consistent with the Federal Rules of Civil Procedure, Rule 6(a).

Absent specific written instructions to the contrary, the Board finds that the "starting date" for the Provider's 45-day deadline was October 21, 1999, the day after the date stamped the Intermediary's denial letter.

With regard to the final day of a time period, CMS has not furnished any specific guidelines on this issue. Section 1395ii of the Medicare statute states that the provisions of Section

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[2] Capeside Cove Good Samaritan Center v. BlueCross BlueShield Association/Cahaba Government Benefit Administrators, PRRB Hearing decision no. 00-0374, Dec. 2005-D7 and St. Edward Mercy Medical Center Fort Smith v. BlueCross BlueShield Association/Arkansas Blue Cross & Blue Shield, PRRB Hearing decision no. 97-1566, Dec 2005-D28.

216(j) of Title II of the Social Security Act "shall also apply with respect to this title to the same extent as they are applicable to Title II." 42 U.S.C. §1395ii. Section 216(j) of the Social Security Act specifically provides that:

> [w]here this title, any provision of another law of the United States . . . relating to or changing the effect of this title or any regulation . . . pursuant thereto provides for a period within which an act is required to be done which affects . . . the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday, or legal holiday . . . then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday or legal holiday.

Thus, under the Medicare statute, the deadline for submitting the Provider's RCL exemption request was automatically extended until December 6, 1999, the first business day after the 45th day, which fell on a Saturday. In light of these statutory provisions, the Board finds that the denial of the Provider's RCL exemption request on the grounds that it was not timely filed was improper.

DECISION AND ORDER:

The denial of the Provider's RCL exemption request on the grounds that it was not timely filed was improper. The Provider's RCL exemption request is remanded to the Intermediary to be considered on its merits.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: September 29, 2005

Suzanne Cochran
Chairman