PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D1

PROVIDER -
Saint Mary's Hospital
Rochester, Minnesota

Provider No.: 24-0010

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
August 23, 2004

Cost Reporting Period Ended -
December 31, 1994

CASE NO.: 98-0502

INDEX

ISSUE:

Was the Intermediary's denial of the Provider's request for an adjustment to its TEFRA target amount due to untimely filing of a request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative 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 portion 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 NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system, Medicare's payment for inpatient Part A hospital operating costs is made on a per-discharge basis; Medicare discharges are classified into diagnostic related groups (DRG) and a specific payment rate is assigned to each DRG with respect to resource use or intensity. However, hospitals and hospital subunits exempt from PPS continue to be paid based upon the lower of their reasonable costs or customary charges. 42 U.S.C. §1395f(b)(1).

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), which modified 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 upon an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost

reporting year, it is entitled to be reimbursed 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, implementing regulations at 42 C.F.R. §413.40 establish procedures and criteria for providers to request and obtain an exemption or an adjustment to their target amount. With respect to the timeless of requests for an adjustment to a provider's TEFRA target amount ceiling, 42 C.F.R. §413.40(e)(1) applies. The language of this regulation was changed in September 1995, and which version of the regulation applies is in issue in this case.

Saint Marys Hospital (Provider) is a nonprofit, short-term acute care facility located in Rochester, Minnesota. On June 24, 1997, Blue Cross and Blue Shield of Minnesota (Intermediary) issued an NPR applicable to the Provider's cost reporting period ended December 31, 1994.[1] On December 22, 1997, the Provider mailed a request for an adjustment to the TEFRA target amount applicable to its rehabilitation unit that is exempt from PPS. The Intermediary received the Provider's request on December 24, 1997 and subsequently denied it for having been received later than 180 days after the pertinent NPR.[2]

The Provider appealed the Intermediary's denial to the Board pursuant to 42 C.F.R.§§ 405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $420,000.[3]

The Provider was represented by David M. Glaser, Esquire, of Fredrikson & Byron, P.A. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that it submitted its TEFRA adjustment request timely in accordance with program instructions contained in Medicare's Provider Reimbursement Manual, Part I (HCFA-Pub.15-1) §3004.2.[4] These instructions require a TEFRA adjustment request to be "submitted" within 180 days of an NPR as opposed to being "received" pursuant to 42 C.F.R. §413.40. The Provider asserts that it mailed its request on the 181st day following the date on its NPR because the 180th day fell on a Sunday, thereby extending the deadline to Monday, the 181st day. The Provider acknowledges that the regulation requiring receipt within 180 days is considered a higher authority than program instructions. However, it asserts that where the program has elected to issue instructions directly to providers, the providers should be able to reasonably rely on them. The Provider believes it is unreasonable to expect providers to review regulations and

[1] Noridian Administrative Services subsequently replaced Blue Cross and Blue Shield of Minnesota as the Provider's intermediary.
[2] See parties' "STIPULATION OF UNDISPUTED FACTS" dated August 19, 2004.
[3] Provider's Final Position Paper at 3.

[4] Provider's Final Position Paper at 5.

statutes to validate every instruction in HCFA-Pub.15-1. The Provider also contends that the 180-day deadline is merely a procedural rule that the Board could waive for justice. See American Farm Lines v. Black Ball Freight Service, 397 U.S. 532, 539 (1970). And finally, the Provider notes that prior to September 1, 1995, 42 C.F.R. §413.40(e) only required TEFRA adjustment requests to be "made" within 180 days of an NPR, which is interpreted the same as being "submitted."[5] The Provider also notes that the regulation change was made after the subject cost reporting period.

The Intermediary contends that the regulation in effect on June 24, 1997, the date the Provider's request was received, is clear, i.e., the Provider's request had to be "received" within 180 days of the NPR to be timely, and it was not.[6] The Intermediary disagrees with the Provider's reliance upon HCFA-Pub.15-1 §3004.2, noting that the manual instruction was issued in August 1994, and that the regulation subsequently tightened the 180-day rule in September 1995.[7] Also, the Intermediary disagrees with the Provider's reliance upon the regulation's wording in 1994, which says that a request must be "made" within 180 days as opposed to "received."[8] The Intermediary asserts that the regulation in place at the time the Provider submits its request for an adjustment to its TEFRA target amount is the applicable regulation, rather than the regulation that was in place during the cost reporting period at issue.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The controlling authority in this case is regulation 42 C.F.R. §413.40(e)(1). The regulation, however, brings two different standards to the case which must be considered. The Intermediary relies upon the wording of 42 C.F.R. §413.40(e)(1) in place at the time the Provider filed its request for an adjustment to its TEFRA target amount (December 22, 1997). Based upon that wording, the Intermediary determined that the Provider's request was untimely filed, as it was not "received" by the Intermediary within 180 days of the pertinent NPR. The Provider relies upon the wording of 42 C.F.R. §413.40(e)(1) in place during the subject cost reporting period, which is the twelve month period ended December 31, 1994. At that time, the regulation required TEFRA requests to be "made" no later than 180 days after the date of an NPR. Based upon this particular wording, the Provider asserts that its request was timely filed, since it was "mailed" on the 181st day of the pertinent NPR, noting that the 180th day fell on a Sunday.

The Board agrees with the Provider. The Board finds it is appropriate to associate the regulation in effect during the Provider's cost reporting period with the Provider's TEFRA request rather than a regulation that was modified and published at a later date. The TEFRA request process is based upon the issuance of an NPR and, therefore, can span several years during which many regulatory changes may occur. Requiring

[5] Provider's Post-Hearing Brief at 2.

[6] Intermediary's Position Paper at 3. Exhibit I-2.

[7] Transcript (Tr.) at 18.

[8] Tr. at 32.

providers to rely upon multiple rules applicable to a particular cost reporting period, especially under these circumstances, appears unreasonable. The Board finds that providers should be able to rely upon a single set of rules applicable to any given cost reporting period. Notably, new regulations and modification to existing regulations are, as a general rule, made effective with the beginning of provider cost reporting periods.

In addition, the Board agrees with the Provider that the date a request is mailed, as in the instant case, is the same as the date a request is "made" as required by the regulation. Program instructions at HCFA Pub. 15-1 §3004.2, authorized by 42 C.F.R. §413.40(e)(1) in effect during the subject cost reporting period, equates the date a request is "made" to the date a request is "submitted," while regulations at 42 C.F.R. §405.1801(a) state:

> *Date of filing* and *date of submission of materials* mean the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined in this subpart. (Emphasis added).

Finally, the Board acknowledges the Provider's argument that its request was filed timely even though it was mailed on the 181st day following its NPR, because the 180th day fell on a Sunday. The Board finds this matter is not in dispute.

DECISION AND ORDER:

The Provider's request for an adjustment to its TEFRA target amount was timely filed in accordance with program regulations. The Intermediary's denial of the Provider's request is reversed. The Provider's request is remanded to the Intermediary for a determination to be made on its merits, i.e., to determine the TEFRA target amount adjustment to which the Provider may be entitled.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S
Anjali Mulchandani-West

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman