# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D43

**PROVIDER -**
Palmetto General Hospital – Skilled Nursing Facility

Provider No.: 10-5990

**vs.**

**INTERMEDIARY -**
Wisconsin Physicians Service

**DATE OF HEARING -**
March 5, 2010

Cost Reporting Period Ended -
December 31, 1998

**CASE NO.:** 02-0162

**INDEX**

ISSUE:

In light of the August 29, 2007 Remand Order from the Administrator of the Centers for Medicare and Medicaid Services ("CMS"), what is the proper regulation and manual provision to apply to the facts of this case and what is the relevance of the Provider's cost reporting period and skilled nursing facility's ("SNF") Medicare certification date with respect to the reimbursement scheme that should govern payments?

MEDICARE STATUTORY AND REGULATORY BACKGROUND**:**

This dispute concerns the Provider's ability to seek a new provider SNF routine cost limit ("RCL") exemption for its fiscal year ended December 31, 1998 ("FYE 12/31/98").

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. 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 to organizations known as fiscal intermediaries or Medicare Administrative Contractors ("MAC"). Fiscal intermediaries or MACs determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20 and 413.24.

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 Amount 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" or "PRRB") within 180 days of the receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).

42 U.S.C. §1395x(v)(1)(A), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. Through regulation, the Secretary established limits on routine care costs, referred to as routine cost limits (RCLs). The Medicare regulations at 42 C.F.R. §413.30(c) permit providers to obtain relief from the cost limits by requesting an exception or exemption.

CMS provides an exemption from the cost limits for approximately the first three years of operation for "new providers." 42 C.F.R. §413.30(e); 44 Fed. Reg. 31802 (June 1, 1979). The exemption may be granted if the provider "has operated as a SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption . . . expires at the end of the SNF's first cost reporting period beginning at least two years after the provider accepts its first patient." 42 C.F.R. §413.30(e).[1] Under 42 C.F.R.

[1] Revised to 42 C.F.R. §413.30(d) per 64 Fed. Reg. 42612 (August 5, 1999).

§413.30(d) (1999), only SNFs with cost reporting periods starting prior to July 1, 1998 can seek a new provider SNF RCL exemption and be cost reimbursed.

Under Provider Reimbursement Manual, Part II ("PRM-II") section 102.1, if a provider is licensed and providing patient care prior to the date that it is first certified for Medicare participation, the provider has the option of having its first cost reporting period begin either as of the first day it is licensed and providing patient care or as of the first day it is certified for Medicare participation.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The underlying legal issue in this case is whether CMS properly denied Palmetto General Hospital's ("Provider" or "Palmetto") request for an exemption from the routine service cost limits ("RCL") for the fiscal year ending December 31, 1998 ("FYE 12/31/98"). On July 2, 2007, the Provider Reimbursement Review Board ("PRRB" or "Board") issued a decision holding that the Provider's FYE 12/31/1998 SNF RCL new provider exemption request from a revised NPR was proper and timely. *See* PRRB Decision No. 2007-D45; Joint Stipulation on Remand dated April 7, 2010 ("JSR") at paragraph 1.

On August 29, 2007, the CMS Administrator issued a decision that did not reach this underlying legal issue. Instead, the CMS Administrator vacated the PRRB's decision and remanded the case back to the PRRB to further develop the record with respect to the 1999 version of the SNF RCL regulation that only permits SNF RCL exemptions for new SNFs with cost reporting periods beginning before July 1, 1998.[2] Since the Board's original decision was vacated, the Board hereby incorporates by reference into this Decision, its original findings, conclusions and holding from PRRB Hearing Decision Number 2007-D45. *See also infra* Decision and Order.

A hearing in this appeal was heard by the PRRB telephonically on March 5, 2010. Thereafter, the Provider and Intermediary entered into a "Joint Stipulation on Remand" dated April 7, 2010. Pursuant to that JSR, the parties agree to the following five key facts and circumstances on remand:

1. The Provider's SNF was state licensed and providing patient care as of December 15, 1997; (JSR at ¶4)
2. The Provider's SNF was first certified for participation in Medicare as of July 21, 1998; (JSR at ¶5)
3. The Provider included the December 1997 and January through June 1998 SNF statistics, for purposes of SNF reasonable cost reimbursement, on its FYE 12/31/98 cost report; (JSR at ¶6)
4. The Provider chose to have it's SNF cost reporting period start when it was first licensed and providing patient care (as opposed to when it was first certified for Medicare participation); and (JSR at ¶7)
5. Thus, pursuant to Provider Reimbursement Manual, Part II (PRM-II) §102.1, for FYE 12/31/98, since the SNF had a cost reporting period that began before July 1, 1998, the

[2] See, JSR at ¶2.

> SNF is entitled to reasonable cost reimbursement, the SNF is not subject to the SNF prospective payment system for its FYE 12/31/98, and the SNF is eligible to seek a new provider SNF RCL exemption for its FYE 12/31/98. (JSR at ¶8)

The Provider was represented by Jon P. Neustadter, Esq., of Hooper, Lundy & Bookman, Inc., while the Intermediary was represented by Stacey Hayes of Wisconsin Physicians Service.

PARTIES' CONTENTIONS**:**

As to the underlying legal issue already addressed and ruled upon by the Board in PRRB Hearing Decision Number 2007-D45, the parties continue to disagree. However, with respect to the issue on remand, the parties are in agreement. *See* JSR. Specifically, pursuant to PRM-II § 102.1, the parties agree that, for FYE 12/31/98, since the SNF had a cost reporting period that began before July 1, 1998, the SNF is entitled to reasonable cost reimbursement, the SNF is not subject to the SNF prospective payment system and the SNF is eligible to seek a new provider SNF RCL exemption.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board hereby adopts as its findings the five aforementioned jointly stipulated facts and circumstances. In particular, when the relevant regulation and manual provision are analyzed together, it is clear that a SNF may choose as the start of its cost reporting period the date a SNF is first licensed and provides SNF patient care. In particular, PRM-II § 102.1(B) reads, in pertinent part, as follows:

> If the provider enters the program at the same time that it begins operations, the initial cost reporting period will begin with the effective date of participation. For example, a hospital that began operations and entered the program on September 15, *2006*, and wished to adopt a reporting period ending date of September 30, must have filed its initial cost reporting covering the period from September 15, *2006*, through September 30, *2007*. It could not have filed the report for the 15-day period ending September 30, *2006*.
>
> If a new provider wished to report on a calendar year basis, began operations on February 1, *2007*, and entered the program on July 1, *2007*, **it could have filed its initial cost report for the period beginning February 1, *2007*, and ending December 31, *2007***, or, alternatively, for the period beginning July 1, *2007*, and ending December 31, *2007*.
>
> If the provider does not begin operations until after the effective date of its entry into the program, the initial reporting period will begin with the first day of the month in which patient care service begins. For example, a hospital which entered the program

> effective August 1, *2007* but did not begin delivering patient care services until September 15, *2007*, and wished to adopt a reporting period ending date of September 30, could have filed its initial cost report covering a period beginning September 1, *2007* and ending on either September 30, *2007* or September 30, *2008*.

PRM-II, § 102.1 (emphasis added).

The Board finds that given that the SNF in this matter was licensed and providing patient care as of December 15, 1997,[3] under the PRM provision, the Provider could have opted for a December 15, 1997 start date for the SNF or a July 21, 1998 start date (when it was first certified for Medicare participation). In light of the fact that the relevant statistics for the December 1997 through June 1998 period for the SNF were <u>included</u> in the FYE 12/31/98 Medicare cost report for purposes of reasonable cost reimbursement, and given the agreement on this point in the JSR, the Board holds that the Provider chose to have its SNF cost reporting begin before July 1, 1998. Thus, the Board holds that under the relevant regulation, 42 C.F.R. § 413.30(d)(1999), the Provider's SNF is entitled to reasonable cost reimbursement, is not subject to the SNF prospective payment system for its FYE 12/31/98, and is eligible to seek a new provider SNF RCL exemption for its FYE 12/31/98.

This decision is consistent with the *Community Care* case: *Community Care Hosp. (New Orleans, La.) v. BlueCross BlueShield Ass'n/TriSpan Health Servs.*, CMS Adm'r Dec. (June 7, 2005), Medicare & Medicaid Guide (CCH) ¶ 81,368; *Community Care, LLC v. Leavitt*, 537 F.3d 546 (5th Cir. 2008) (affirming the CMS Administrator decision). In the *Community Care* case, a SNF that was first certified for Medicare participation in April 1999 and that also treated its first patient in April 1999 was deemed to have its own cost reporting period starting in April 1999 (and thus, since that is after July 1, 1998, it would be subject to SNF PPS and not reasonable cost reimbursement). However, the *Community Care* case relied on other parts of PRM-II § 102.1, because, unlike in this case, the provider in *Community Care* was not licensed and providing patient care prior to July 1, 1998.

<u>DECISION AND ORDER</u>**:**

Since the Board's original decision was vacated, the Board hereby incorporates by reference its original findings, conclusions and holding from that PRRB Hearing Decision Number 2007-D45 into this decision. Further, for all the foregoing reasons, the Board holds that the Provider's SNF cost reporting period began prior to July 1, 1998 and in accordance with PRM II §102.1 and 42 C.F.R. §413.30(d) the SNF qualifies for reasonable cost reimbursement and has the ability to seek a SNF RCL new provider exemption.

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[3] This is an undisputed fact. *See* JSR at ¶ 4.

BOARD MEMBERS PARTICIPATING**:**

Suzanne Cochran, Esq. (Recused)
Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Board Member

DATE: September 13, 2010