CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Saint Anthony's Health Center	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/91, 12/31/92**
Provider	
vs.	
Blue Cross Blue Shield Association/ AdminaStar Federal Illinois	**Review of: PRRB Decision 2006-D55 Dated: September 27, 2006**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the CMS' Center for Medicare Management (CMM) requesting reversal of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the full amount of Provider's exception requests to the skilled nursing facility (SNF) routine service cost limits under 42 C.F.R. §413.30(f) was properly denied because the Provider did not request the exceptions within 180 days of the original notices of program reimbursement (NPR).

The Board held that the Provider is entitled to consideration of the full amount of the exception request based on the appeal of its revised NPR. First, the Board stated that the Intermediary was unaware of CMS' position of limiting any relief from a revised NPR adjustment to the incremental increase in the amount the provider's costs

exceeded its revised cost limit. The Intermediary had recommended to CMS, the acceptance of more than the incremental increase in the adjustments on the revised NPRs.[1] CMS' notice to all intermediaries concerning the adjustments to the RCLs authorizes adjustments to exceptions already granted and it addresses how new exception requests will be handled.[2] That communication demonstrates that CMS anticipated that exception requests would be filed from revised NPRs yet there is no mention of a limit on any relief from a revised NPR adjustment to the incremental increase only.

The Board found no basis for CMS' limitation in the regulations at 42 C.F.R. §§405.413.30(c) and 405.1889. 42 C.F.R. §§405.413.30(c) states that the "provider's request for an exception must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement." The Board noted that the regulation does not make a distinction between types of NPRs; therefore, a provider should be allowed to make an exception request for the full amount from any NPR in which the RCL is at issue.

The Board further stated that even when §405.1889 is applied, the appeal from the revised NPR was proper. The Board found that this case is distinguishable from French Hospital Medical Center v. Shalala, 89 F.3d 1411 (9th Cir. 1996), in which a provider was not allowed to contest its cost limits from a revised NPR where the provider sought an exception from an adjustment for malpractice insurance costs. The court held the denial of the exception request was proper because "[n]either the RCL, nor components of the RCL, were at issue in the revised NPRs." In this instance, the Intermediary did adjust the RCLs in the revised NPRs; thus, the Provider is entitled to make its exception requests from the revised NPRs.

SUMMARY OF COMMENTS

CMM commented requesting that the Administrator reverse the Board's decision. CMM argued that a revised NPR does not give a provider new appeal rights for an issue that could have been appealed under the original NPR—where the provider did not exercise its appeal rights timely. In accordance with existing regulations, where a revision is made on the amount of program reimbursement after such determination has been reopened, such revision is a separate and distinct determination. CMM argued that the courts in several federal decisions hold that in the case of a reopening, only matters contained in the revised NPR can be appealed. These cases state that the

[1] Intermediary Exhibit 5.
[2] Intermediary Exhibit 3 at p.2.

revised NPR does not revive appeal rights flowing from the original NPR if the provider failed to exercise those original appeal rights timely.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 C.F.R. §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

In response to rising costs, and realizing that the original structure of reasonable costs provided little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary to establish cost limits. Specifically, the Secretary has the authority to:

> [p]rovide for the establishment of limits on the direct or indirect overall incurred costs… based on estimates of the costs necessary in the efficient delivery of needed health services….

SNF cost limits are established based upon reported costs that are adjusted for actual or projected cost changes by applying the SNF market basket index. When the cost limits are calculated, the limits are based on an estimated market basket index that in turn are based upon forecasts of economic trends that may be retroactively adjusted to reflect the actual index. The market basket index is determined after the cost reporting period to which the limits apply is closed. The market basket index is used than to adjust the limits to reflect cost changes occurring between the time of the cost reporting periods represented in the cost limits data and the time when the limits are applied.

Recognizing that providers under some circumstances would incur costs in excess of the routine cost limit, the regulation at 42 C.F.R. §413.30 establishes the SNF routine service cost limits and provides for a SNF exception to the limits. The regulation at 42 C.F.R. §413.30(f) states:

> Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section…. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

In accordance with §413.30(c), the SNF must make its request for an exception to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement or NPR.[3] In pertinent part, the regulation states:

> [t]he provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to CMS [formerly HCFA], which makes the decision. CMS responses within 180 days from the date CMS received the request from the intermediary. The intermediary notifies the provider of CMS' decision. The time required for CMS to review the request is considered good cause for the granting of an extension of time to apply for Board review as specified in 405.1841 of this chapter. CMS' decision is subject to review under subpart R of part 405 of this chapter.

Regarding the appeal of an exception request under subpart R, the regulation at 42 CFR 405.1801, et seq,, provides procedures for appealing final determinations consistent with section 1878 of the Act. Generally, Section 1878(a) of the Social Security Act provides that any provider of services which has filed a required cost report within the time specified in regulation, may obtain a hearing with respect to such cost report by Board if, "such provider is dissatisfied with a final determination of its fiscal intermediary as to the amount of total program reimbursement due the provider"; the amount in controversy is $10,000 or more; and the provider files a

[3] At the close of its fiscal year, a provider must submit a cost report to its 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 an NPR.

request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(a)(i).” The regulation at 42 CFR 405.1835 and 42 CFR §405.1841(a)(1) implements these statutory provisions.

However, the regulation at 42 C.F.R. §405.1885 also allows for a cost report to be reopened under certain limited circumstances on specific “matters at issue in such determination.” The effects of reopening and revising an NPR are addressed at section 405.1889, which explains that, where a revision is made in a reimbursement determination after reopening, a provider's appeal rights are limited to the “separate and distinct determination” that results from the reopening to which the provisions of sections 405.1811, 405.1835, 405.1875 and 405.1877 are applicable. Thus, in the event that a specific reimbursement matter is reopened and revised, a provider's appeal rights are limited to the particular substantive matter that was revised, and do not extend to other substantive matter that were finalized in the initial NPR, but not subsequently reopened or revised. Thus, the appeal rights for such a revised determination is limited by regulation and does not flow from Section 1878 of the Act.

The regulation at 42 CFR 413.30 shows that an exception request and the appeal of such a request is intricately related to the NPR. While a provider may request an exception of the RCL within 180 days of its NPR, any appeal to the Board of the CMS determination on that request Board is through the appeal of the NPR. Therefore, a request for an exception made pursuant to a revised NPR will also be limited to the provisions of 42 CFR 405.1889 on appeal to the Board. To the extent that CMS allows an exception request to be made pursuant to a revised NPR, any relief will be limited to those costs affected by such a revision.

In this case, the Intermediary issued the Provider's original NPRs on September 2, 1993 for its fiscal year ended December 31, 1991 cost report and on April 1, 1994 for its FYE December 31, 1992 cost report. The Provider's routine costs exceeded the RCLs for both FYEs 1991 and 1992 and the Provider did not file exception requests with the Intermediary within 180 days of the original NPRs for either fiscal year as provided for under 42 C.F.R. 413.30(c).

The Intermediary issued notices of reopenings for FYEs 1991 and 1992 to update the SNF cost limits based on the market basket index. For both FYE 1991 and 1992 the change in the market basket index decreased the Provider's routine cost limit amount. As a total, the Provider's costs exceeded the cost limit under the original NPR plus the additional, incremental amount as a result of decreasing the cost limit, per the revised market basket, under the revised NPR.

The Provider filed exception requests for both FYE 1991 and 1992 within the 180 days of the revised NPRs as provided for under 42 C.F.R. 413.30(c). The Intermediary approved the exceptions for the incremental increase in the amount of costs that exceeded the RCL between the original NPRs and the revised NPRs. The Provider subsequently filed timely appeals requesting relief for the full amount in which its costs exceeded its cost limit for both FYEs 1991 and 1992 under both the original NPR and the revised NPR.

The Administrator finds that CMS properly determined that the Provider's requests for RCL exceptions made pursuant to the revised NPRs are limited by the provisions of 42 CFR 405.1889 to items and costs adjusted on those revised NPRs. Moreover, CMS properly determined that an adjustment for purposes of the application of the market basket pursuant to the revised NPRs did not open to challenge all costs originally denied under the RCL. Rather, CMS properly found that only those incremental costs denied as a result of the application of the revised market basket pursuant to the revised NPRs could be subject to relief. This policy is consistent with distinctive rights, only prescribed by regulation and not from the statute, which flow from a revised NPR.

As the regulation shows, an exception request is intricately related to the NPR. Likewise, an exception request made pursuant to a revised NPR is intricately related to those items and costs adjusted in the revised NPR. A revised NPR does not give a provider new appeal rights for costs that could have been appealed under the original NPR. Likewise, a provider's request for an exception made pursuant to a revised NPR is limited to those items and costs at issue in the revised NPR. Finally, the Board's review of any appeal of a determination on that exception request is also limited to those items and costs adjusted on the revised NPR as it is the revised NPR that forms the basis for Board jurisdiction.

In sum, the record shows that the Provider did not exercise its rights to request an exception within the required 180-day period of the original NPRs as set forth at 42 C.F.R. §413.30(c) for costs that exceeded the limits, but rather requested an exception from the revised NPRs issued as a result of the revised market basket. The Administrator finds that CMS' policy is consistent with the regulations at 42 C.F.R. §413.30(c) and 42 C.F.R. §405.1889 in prohibiting a SNF from receiving relief from costs that exceeded the RCL which were not affected by the revision of the NPR.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/22/06 /s/

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services