CENTERS FOR MEDICARE & MEDICAID SERVICES
Order of the Administrator

IN THE CASE OF:	**CLAIM FOR:**
Palmetto General Hospital **Provider**	**Fiscal Years Ending: 12/31/98**
vs.	**REVIEW OF:**
Blue Cross and Blue Shield Association	**PRRB Case No. 2007-D45**
Intermediary	**Dated: July 2, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)] and 42 CFR 405.1875. The parties were notified that the Administrator would review the Board's decision. Subsequently, the Provider requested that the Administrator affirm the Board's decision. The Intermediary requested that the Administrator reverse the Board's decision. Accordingly, the case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether CMS properly denied the Provider's request(s) for an exemption from the routine cost limits (RCLs) for the fiscal year ended December 31, 1998.

The Board ruled separately on the two RCL exemption requests. The Board determined that the first request was filed more than 180 days after the initial Notice of Program Reimbursement (NPR). Therefore, it was not timely filed and was properly denied by CMS. The Board determined that the second request was improperly denied by CMS because the request was filed timely based on the

Notice of Correction or Revised Notice of Program Reimbursement (Revised NPR). The Board remanded the request to CMS for a determination on the merits.

SUMMARY OF COMMENTS

The Provider commented, requesting that the Administrator affirm the Board's decision. The Provider argued that the Intermediary and CMS erred when they denied the Provider's request for an exemption from the RCL for the 1998 fiscal year. The relevant regulatory and agency authorities confirm that the Provider was well within its rights to seek an exemption based on the Intermediary's revised NPR.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that the Board made an erroneous interpretation of the regulation and manual instructions. The Intermediary asserts that the proper interpretation of the regulation and instructions requires an exemption request to be filed within 180 days of the initial NPR.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and included in the record.

In this case, the Board focuses on the proper application of the 180-day filing limit imposed under 42 CFR §413.30(c) of the Medicare regulations. The Board relied upon the regulation in effect in 1998, presumably because those regulations corresponded to the fiscal year end in question (in this case, 1998).

The regulation at 42 CFR 413.30(c)(1998) stated that:

> Provider requests regarding applicability of cost limits. Except for the per-beneficiary limitation that applies to HHAs, a provider may request a reclassification, exception, or exemption from the cost limits imposed under this section. In addition, a hospital may request an adjustment to the cost limits imposed under this section. The 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 HCFA, which makes the decision. HCFA

> responds to the request within 180 days from the date HCFA receives the request from the intermediary. The intermediary notifies the provider of HCFA's decision. The time required for HCFA to review the request is considered good cause for the granting of an extension of the time limit to apply for a Board review, as specified in Sec. 405.1841 of this chapter. HCFA's decision is subject to review under subpart R of part 405 of this chapter.

Specifically with regard to exemptions, the regulation at 42 CFR 413.30(e)(1998) provided:

> Exemptions. Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

However, important changes were made in 1999. The final rule published at 64 Federal Register 42610 (August 5, 1999), entitled "Medicare Program; Revision of the Procedures for Requesting Excpetions to Cost Limits for Skilled Nursing Facilities and Elimination of Reclassifications" changed how providerds could request exceptions and exemptions. The preamble to the final rule explained that this change was made in accordance with the Balanced Budget Act of 1997 (BBA) implementation of the SNF prospective payment system. The Secretary stated that:

> Section 4432 of the Balanced Budget Act of 1997, (Public Law 105-33) enacted August 5, 1997, mandates that a prospective payment system for SNFs be implemented effective for cost reporting periods beginning on or after July 1, 1998. This prospective payment system will replace the retrospective reasonable cost based system currently used by Medicare for payment of SNF services. *Accordingly, exceptions will no longer be available to SNFs with cost reporting periods beginning on or after July 1, 1998. Fiscal intermediaries will continue to process, beyond July 1, 1998, SNF exception requests for cost reporting periods beginning before July 1, 1998.* [Emphasis added] [1]

[1] 63 Federal Register 42797 (August 11, 1998).

Therefore, the regulation 42 CFR 413.30(c)(1999) was changed to read:

> Requests regarding applicability of cost limits. *For cost reporting periods beginning before July 1, 1998, a SNF may request an exception or exemption to the cost limits imposed under this section.* …The SNF …must make its request to its fiscal intermediary within 180 days of the date on the intermediary's notice of program payment.
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> (2) Skilled nursing facilities. The intermediary makes the final determination on the SNF's request and notifies the SNF of its determination within 90 days from the date that the intermediary receives the request from the SNF. If the intermediary determines that the SNF did not provide adequate documentation from which a proper determination can be made, the intermediary notifies the SNF that the request is denied. The intermediary also notifies the SNF that it has 45 days from the date on the intermediary's denial letter to submit a new exception request with the complete documentation and that otherwise, the denial is the final determination. The time required by the intermediary to review the request is considered good cause for the granting of an extension of the time limit for the SNF to apply for a PRRB review, as specified in Sec. 405.1841 of this chapter. The intermediary's determination is subject to review under subpart R of part 405 of this chapter. [Emphasis added.]

The regulation at 42 CFR 413.30(d)(1999) states regarding exemptions, consistent with the BBA, that:

> Exemptions. *Exemptions from the limits imposed under this section may be granted to a new SNF with cost reporting periods beginning before July 1, 1998 as stated in Sec. 413.1(g)(1).* A new SNF is a provider of inpatient services that has operated as the type of SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than 3 full years. An exemption granted under this paragraph expires at the end of the SNF's first cost reporting period beginning at least 2 years after the provider accepts its first inpatient. [Emphasis added.]

The Provider, which is a hospital-based SNF, was not certified to participate in the Medicare program until July 21, 1998, as shown on the Hospital complex cost report. However, the Hospital complex cost reporting period was January 1, 1998 through December 31, 1998. As a preliminary matter, the record does not address which law and regulation is to be applied to the Provider's exemption requests and whether the controlling fact is the beginning date of the Hospital Complex cost reporting period or the date of the Provider's certification. Consequently, the Administrator finds that remand of the case is appropriate to allow the further development of the record.

Accordingly, the Administrator orders that Board's decision is vacated and the case is remanded to the Board; and

That on remand the Board shall further develop the record as to the impact of the BBA, the substantive and procedural laws and regulations that are to be applied to the Provider's cost year at issue, and the controlling or relevant facts; and

That the Board shall determine whether the CMS' actions denying the requests were proper; and

That the final decision of the Board will be subject to the provisions of Section 1878(f) of the Social Security Act and 42 CFR 405.1875.

Date: 8/29/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services