CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Davies Medical Center	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 1983**
Provider	
vs.	**Review of:**
BlueCross BlueShield Association/ First Coast Service Options, Inc. (formerly United Government Services)	**PRRB Dec. No. 2010-D46**
Intermediary	**Dated: September 17, 2010**

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 mandated 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. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether the Intermediary properly denied the Provider's Tax Equity and Fiscal Responsibility Act (TEFRA)[1] exception request. The Board concluded that the Provider had a right to file its application for an exception within 180 days of the issuance of the revised Notice of Program Reimbursement (NPR), but that its filing was not timely. The Board noted that, in reaching this conclusion, it addressed whether the Provider's request for an exception was filed on a timely basis, whether the Provider may apply for an adjustment to a rate of increase ceiling within 180 days after issuance of a revised NPR, and, if so, whether the resulting adjustment must be limited to items addressed in the revised NPR.

[1] Pub. L. No. 97-248.

The Board found that 42 C.F.R. § 405.463 (1983), the regulation in effect at time of the issuance of the Provider's initial NPR[2], read as follows:

> (e) *Hospital request regarding applicability of the rate-of-increase ceiling.* A hospital may request an exemption from or exception to the rate of cost increase ceiling imposed under this section. The hospital's request must be made to its fiscal Intermediary no later than 180 days from the date on the Intermediary's notice of amount of program reimbursement.

At the time of issuance of the revised NPR, dated January 31, 1996, 42 C.F.R. §413.40 stated:

> (e) *Hospital requests regarding adjustments to the payment allowed under the rate-of-increase ceiling.* (1) Timing of application. A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's **initial** notice of amount of program reimbursement (NPR) for the cost reporting period for which the hospital requests and adjustment. (Emphasis added.)

The Board concluded that the regulation in effect at the time the initial NPR was issued posed no limitation on the type of NPR (initial or revised) from which a hospital may request an exception. Effective in 1995, the regulation was changed to limit a provider's exception request to an initial NPR. The Board found that, although the amended regulation was in effect when the Intermediary issued the revised NPR in January 1996, the Provider could not have complied with the new rule effective in 1995, which was 10 years after the original NPR was issued on March 29, 1985, as the 180 day time limit from the original/initial NPR would have long passed. Further, the application of the 1995 revision, requiring the hospital's request to be made within 180 days from the initial NPR, effectively would have cut off a provider's right to make such a request. The Board concluded that the revised regulation would apply only to initial NPRs issued on, or after, the effective date of the revised regulation.

With regard to whether adjustments to the rate-of-increase ceiling must be limited to items addressed in the revised NPR, the Board found no basis for limiting the relief from a revised NPR to the incremental increase only. The Board noted that 42 C.F.R. § 405.1889 states:

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[2] While the Board noted that 1983 was the year the initial NPR was issued, the initial NPR was actually dated March 29, 1985. *See* Intermediary's Final Position Paper, Exhibit I-5. However, the regulation at 42 C.F.R. § 405.463 is the same for 1985 as 1983.

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

The Board stated that this section deals exclusively with the appeal rights of providers pursuant to a revised NPR, but clearly imposed no threshold limits on the scope of the provider's exception request. The regulation at 42 C.F.R. § 413.463(e), which sets the procedural limits for exception requests, makes no distinction between the types of NPR and provides no basis upon which to limit relief for a request. Accordingly, the Board concluded that, under the applicable regulations, a provider is allowed to make an exception request to the rate of increase ceiling for any amount within 180 days of any NPR in which the rate-of-increase ceiling is at issue, and there is no basis to limit a provider's exception request to the effect of issues adjusted in a revised NPR.

With regard to the timeliness of requesting an exception, the Board noted that the regulation in effect in 1995 required that the hospital's request be received by the intermediary no later than 180 days after the date on the Intermediary's initial NPR, and that in this case, the Provider's request for an exception was received more than 180 days after the date of the revised NPR.

Thus, the Board found that, although the Provider had a right to file an exception request from the revised NPR, the Provider failed to file the request within 180 days. The Board concluded that the request was untimely and the Intermediary's denial of the exception was affirmed.

SUMMARY OF COMMENTS

No comments were received in this case.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

In enacting TEFRA in 1982, Congress modified Medicare reimbursement by providing hospitals with incentives to render services more efficiently. Prior to that time, Medicare

reimbursed hospitals and other health care providers on the basis of the "reasonable cost"[3] of services, with limits only on allowable routine costs.[4] Among the TEFRA provisions, § 101 added § 1886(b) to the Medicare Act to establish a ceiling on the allowable rate of growth for hospital inpatient operating costs.[5] Specifically, Section 1886(b) provided that payment for inpatient operating costs would be based on the relationship between a provider's actual costs and a ceiling, determined by a target rate of increase in operating costs per case.

TEFRA also added § 1886(b)(4)(A) to the Act, establishing the Secretary's authority to grant an exemption from, or an adjustment or exception to, a provider's rate-of-increase ceiling. It states in part:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services…that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

The implementing regulation in existence at the time of the original NPR in 1985, 42 C.F.R. § 405.463, noted that exception requests had to be made to the intermediary no later than 180 days from the date on the intermediary's NPR, without specification as to type of NPR (initial or revised).[6] Exceptions would only be made for extraordinary circumstances beyond the hospital's control, such as strikes, fire, earthquakes, floods, or similar unusual

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[3] Section 1861(v)(1)(A) of the Act defines "reasonable cost" as: " ... the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services...."

[4] Pursuant to § 223 of the Social Security Amendments of 1972, Pub. L. No. 92-603, the Secretary imposed limits on reimbursement for routine operating costs, which are commonly referred to as "the section 223 limits." See 42 CFR 405.460 (1974).

[5] Section 1886(a)(4) of the Act provides: "the term 'operating costs of inpatient hospital services' includes all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services...."

[6] 42 C.F.R. § 405.463(e) (1985 ed.)

occurrences with substantial cost effects, or for a change in case mix.[7] Adjustments could be made to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services, including adjustments of base period costs to include FICA taxes, and services billed under Part B of Medicare during the bas period, but paid under Part A during other cost reporting periods.[8]

Under the implementing regulation in existence in 42 C.F.R. § 413.40 at the time of the issuance of the revised NPR and the Provider's exception request in 1996, requests for adjustments[9] had to be received by the intermediary no later than 180 days after the date on the intermediary's initial NPR. Adjustments would be made for extraordinary circumstances, adjustments for distortion[10], and adjustments for significant wage increases occurring between the base period and the cost reporting period subject to the ceiling if there is a significant increase in the average hourly wage for the geographic area in which the hospital is located.

More importantly, at the time of the issuance of the revised NPR and the Provider's exception request in 1996, § 413.40(e)(4) provided, in pertinent part, that the final decision regarding an adjustment:

> is subject to review under the provider reimbursement determination and appeal procedures in subpart R of part 405 of this chapter, provided the hospital has received an NPR for the cost reporting period in question, **and**

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[7] 42 C.F.R. § 405.463(g) (1985 ed.)

[8] 42 C.F.R. § 405.463(h) (1985 ed.)

[9] The preamble to the Aug. 30, 1991 Final Rule noted that there had been confusion in the use of the term "exceptions" under 42 C.F.R. § 413.40(g) and "adjustments" under § 413.40(h), and noted there was no substantive difference between the two terms are applied under 42 C.F.R. § 413.40, and that the terms could be used interchangeably to describe the general procedure for adjusting a hospital's costs for purposes of determining the target amount. To eliminate confusion, the Final Rule noted that the term "exceptions" would no longer be used to describe these adjustments, and 42 C.F.R. § 413.40(e) was modified accordingly. 56 *Fed. Reg.* 43196 (Aug. 30, 1991).

[10] Adjustments for distortion may take into account FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period, malpractice insurance costs (if malpractice costs were not included in the base year operating costs), increases in service intensity or length of stay attributable to changes in the type of patient served, a change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs, and the manipulation of discharges to increase reimbursement, among other things.

> **the NPR disallows costs for which the hospital had requested an adjustment** (see the definitions in § 405.1801(a) of this chapter and the provisions regarding a provider's right to a Board hearing in § 405.1835 of this chapter).[11] (Emphasis added.)

The Board interpreted 42 C.F.R. § 413.40(e) as allowing a provider to request an adjustment to its TEFRA limits pursuant to a revised NPR. However, when interpreting a statute (or regulation), the Administrator finds that all parts should be construed together so as to produce a harmonious whole.[12] Thus, the Administrator finds that the regulation at § 413.40(e) must be read in a manner which is consistent with the scope of the appeal set forth at § 1878 of the Act and the regulations at 42 C.F.R. § 405.1801 , *et seq*., and in particular 42 C.F.R. §405.1889.

With respect to a Board Hearing, § 1878(a)(1) of the Act provides that any provider of services which has filed a required cost report may obtain a hearing with respect to such cost report by the Board if the provider:

> (A) (i) is dissatisfied with a final determination of the [intermediary] as to the amount of total program reimbursement due the provider ... for which payment may be made under this title for the period covered by such report ...
> (2) the amount in controversy is $10,000 or more, and
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

Consistent with the statute, the regulations at 42 C.F.R. § 405.1835(a) state that a provider has a right to a hearing before the Board on an intermediary's determination, if:

> (1) An intermediary determination has been made with respect to the provider; and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in 405.1841(a)(1); and
> (3) The amount in controversy (as determined in Section 405.1839(a)) is $10,000 or more.

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[11] 58 Fed. Reg. 46270, 46323-33 (1993). HCFA explained that: "the term 'disallowed costs' encompasses both costs that have been disallowed by the ... intermediary as unreasonable and therefore, will not be reimbursed by Medicare regardless of the TEFRA limits, and those costs that are allowable but were not reimbursed since they exceeded the TEFRA target amount. These latter costs are the subject of adjustment requests." 58 Fed. Reg. 46323-33.

[12] *See* SUTHERLAND, STATUTES AND STATUTORY CONSTRUCTION, VOLUME 2, § 368 (2008).

Generally, an intermediary determination is reflected in a notice of program reimbursement or NPR. According to 42 C.F.R. § 405.1801(a)(1), an "intermediary determination" is defined as:

> A determination of the amount of total reimbursement due the provider, pursuant to section 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

Under 42 C.F.R. § 405.1841(a)(1) :

> [t]he request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider....

Thus, under the statutory and regulatory scheme, a provider's failure to timely appeal an original NPR deprives the Board of jurisdiction over a claim based on that NPR.

However, the regulation at 42 C.F.R. § 405.1885 allows for a cost report to be reopened under certain limited circumstances. The effects of reopening and revising an NPR are addressed at § 405.1889, which states that:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.185, **such revision shall be considered a separate and distinct determination or decision** to which the provisions of Sections 405.1811, 405.1835, 405.1875 and 405.1877 are applicable. (Emphasis added.)

Thus, if a specific reimbursement matter is reopened and revised, a provider's appeal rights are limited to the particular matter that was revised, and do not extend to other matters that were finalized in the initial NPR, but not subsequently reopened or revised. To hold otherwise, i.e., to permit appeal of issues not considered in the reopening that could have been appealed within 180 days of the original NPR, would be contrary to the plain meaning of the limitations period in § 1878(a)(3) of the Act.[13]

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[13] The Secretary's position has been upheld by the majority of courts that have considered the issue. *See HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *Albert Einstein Medical Center v. Sullivan*, 830 F. Supp. 846 (E.D. Pa. 1992), aff'd, 6 F.3d 778 (3d Cir. 1993); *French Hospital Medical Center v. Shalala*, 841 F. Supp. 1468 (N.D. Cal. 1993), aff'd, 89 F.3d 1411 (9th Cir. 1996); *Rutland Regional Medical Center v.*

Thus, the Administrator finds that the Medicare regulations limit the scope of administrative review of revised NPRs to matters the fiscal intermediary reconsidered in revising the 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. [14] 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. The U.S. Court of Appeals for the District of Columbia Circuit[15] upheld the Secretary's ruling that:

> when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive from the federal government under the Medicare program, a provider's appeal of that reopening to the Provider Reimbursement Review Board is limited to the specific issues revisited on reopening and may not extend further to all determinations underlying the original reimbursement decision for that financial year.[16]

Sullivan, 835 F. Supp. 754 (D. Vt. 1993); *Delaware County Memorial Hospital v. Sullivan*, 836 F. Supp. 238 (E.D. Pa. 1991); *South Miami Hospital v. Bowen*, 658 F. Supp. 544 (S.D. Fla. 1987).

[14] For example, paragraph (e)(5) of 42 C.F.R. § 413.40 (1995 ed.), "Extending time limit for PRRB review of NPR", explained that "The time required to review the request is considered good cause for the granting of an extension of the time limit to apply for review of the notice of amount of program reimbursement by the Provider Reimbursement Review Board". That is, the appeal of the CMS determination on the exception request is a part of the NPR appeal and not a standalone appeal right. This is also consistent with the practical implications of effectuating any successful appeal of an exception denial.

[15] *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (U.S. Ct. of Appeal, Dist. Of Columbia Circ., 1994)

[16] This issue-specific reading of appeal rights after reopening has been upheld by a number of courts. *See, e.g., Anaheim Memorial Hosp. v. Shalala*, 130 F.3d 845 (9th Cir. 1997); *Edgewater Hosp., Inc. v. Bowen*, 857 F.2d 1123, 1134 (7th Cir. 1988), *Albert Einstein Medical Ctr. v. Sullivan*, 830 F.Supp. 846 (E.D. Pa. 1992), *aff'd* 6.F3d 778 (3rd Cir. 1993); *Delaware County Memorial Hosp. v. Sullivan*, 836 F.Supp. 238 (E.D. Pa. 1991); *French Hosp. Medical Ctr. v. Shalala*, 841 F.Supp. 1468 (N.D. Cla. 1993)), aff'd, 89 F.3d 1411 (9th Cir. 1996).

In this case, the Intermediary had proposed an adjustment to amend the Provider's TEFRA target limit to agree with an audited base year (Fiscal Year 1983) report. Subsequently, as part of a partial administrative resolution, dated December 4, 1995 resolving Issue Number 12 of the Provider's PRRB Case No. 85-0178 (also for FY 1983), the Intermediary proposed a reopening adjustment that recomputed the cost per discharge. Issue Number 12 involved the count of available beds, and the resolution agreed to include 46 beds that were omitted in the original computation of the TEFRA target rate. As a result, the Intermediary reopened the cost report to amend the cost per discharge, and issued a revised NPR dated January 31, 1996. On July 26, 1996, the Provider wrote to the Intermediary requesting an exception to the TEFRA target limit. On July 29, 1996, the Provider also appealed the correctness of the TEFRA target rate limitation to the Board, contending that it had been incorrectly determined and that it was entitled to an exception.[17]

The Intermediary denied the Provider's exception request on August 16, 1996, for two reasons. First, the Intermediary stated that the revised NPR dated January 31, 1996 only contained revisions related to available beds, and that the issue of available beds was not related to the criteria the Providers had to satisfy in order to obtain an exception to the TEFRA target rate. Second, the appeal request would have had to be filed with the Intermediary within 180 days of the revised NPR, however, the Intermediary did not receive the request until after July 30, 1996, when the 180 days had expired, thus, the request was not timely. The Provider appealed the Intermediary's denial of the request for an exception to the Board on November 12, 1996.

A review of the record demonstrates that the Provider did not file its exception request within 180 days of the initial NPR, and also failed to file its request within 180 days of the revised NPR.[18] Consequently, the Intermediary properly determined that the Provider's

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[17] The Board apparently considered this appeal to be premature. *See* PRRB Jurisdictional Ruling, dated January 10, 2008, which notes in the background, "This appeal was filed on November 12, 1996, from the Intermediary's August 16, 1996 denial of the Provider's request for an exception to the TEFRA Target Rate."

[18] The Administrator also disagrees with the Board's conclusion that the Provider could not have complied with the regulation in effect at the time the revised NPR was issued, which required exception requests to be made only from initial NPRs. The Board concluded that the 1996 revision should apply only to initial NPRs issued on, or after, the effective date of the revised regulation in 1995. However, the rule changes were clarifications and consistent with longstanding rules controlling revised NPRs and finality. Moreover, the Provider would have no reasonable expectation or right to expect a revision to its NPR upon which a later exception could be filed. In other words, the Provider could not reasonably argue that it allowed its initial opportunity to request an exception (following the issuance of its initial NPR in 1985) to lapse 180 days after the initial NPR because it expected to request such an

request for an exception was untimely filed. Moreover, the Administrator also finds that the Provider would have been limited, in its exception request, to the scope of the revised NPR, even, assuming, *arguendo*, it had been timely made. In this case, even if the request had been timely made, the matters involved in the exception request were not the subject of the revised NPR. The matter revised on the NPR involved cost per discharge based on the addition of 46 bed days that were omitted in the original computation of the TEFRA target rate. The adjustment did not result in any additional disallowances under the TEFRA limit. In fact, the Provider admitted that the adjustment made in the revised NPR actually increased the TEFRA limitation, meaning it had less disallowed reimbursement than under the original NPR.[19] Thus, the Provider's request for an adjustment for the amount disallowed under the TEFRA limits, based on atypical services, would have had to be made pursuant to its original NPR. The atypical services issue is not related to the subject of the revised NPR, and the revised NPR did not result in the TEFRA disallowances for which the Provider requested an adjustment. Accordingly, the Administrator finds that, as the Provider's request for an adjustment to its TEFRA limits was not related to matters revised on the NPR, it could not request an exception request based on the revised NPR.[20]

The Administrator notes that although the Board found that 42 CFR § 405.1889 does not have to be considered in this case, the record demonstrates that the Provider requested an exception pursuant to the revised NPR and that had there been no reopening of the Provider's FYE 1983 cost report and a revised NPR issued, all of the Provider's appeal rights would have been extinguished. Because the Provider's only possible right to a determination on its exception request and subsequent Board review is as a result of a reopening and the issuance of a revised NPR, the reopening regulations at 405.1889, in addition to the regulation at 42 C.F.R. § 413.40(e), are directly applicable to this case. As such, the Board's jurisdiction over this appeal itself is limited to those matters revised on the revised NPR. Hence, even assuming, arguendo, that the exception request would have been made within 180 days, the Board's jurisdiction did not extend to matters raised in the exception request.

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exception from any revised NPRs that might, or might not, be issued. Therefore, the regulation in effect when the revised NPR was issued and the Provider requested the exception is controlling.

[19] Transcript of Oral Hearing (Tr.) pp. 38-40. The Provider also admitted that the TEFRA exception problem existed outside of the reopening, and that the adjustments made by the Intermediary in the revised NPR gave the Provider the remedy it had requested, and could not have cured the TEFRA problem in any way. Tr. pp. 65-66.

[20] The facts in this case are very similar to those in *Foothill Presbyterian Hospital v. Shalala*, 152 F.3d 1132 (9th Cir. 1998). In that case, the Ninth Circuit Court of Appeals upheld the Administrator's ruling that the Hospital's exception request was untimely because any exception request was limited to the specific issues addressed in the revised NPR.

This foregoing reading of 42 C.F.R. § 405.1889 is also consistent with the regulation at 42 C.F.R. § 413.40(e)(4), which states that a provider has a right to a Board hearing "provided the hospital has received an NPR for the cost reporting period in question **and the NPR disallows costs for which the hospital has requested an adjustment.**" Therefore, even assuming, *arguendo*, the Provider had timely filed its exception request, the Provider would not have a right to a Board hearing on the matter, as the NPR did not disallow costs for which the hospital had requested an adjustment.

DECISION

The Board's decision is vacated for lack of jurisdiction.

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

Date: 11/1/10

/s

Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services