PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D44

PROVIDER -
Covenant Shores Health Center
Mercer Island, WA

Provider No.: 50-5504

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal Illinois

DATE OF HEARING -
February 10, 2005

Cost Reporting Periods Ended -
January 31, 1998 and January 31, 1999

CASE NO.: 99-4061

INDEX

ISSUE:

Whether CMS' denial of the Provider's request for an exemption to the routine cost limits for skilled nursing facilities as a new provider was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. 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 the providers under Medicare law and under interpretive 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 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 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 1819(a)(1) of the Social Security Act defines a Skilled Nursing Facility (SNF) as an institution engaged in providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) establishes the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. These limitations are called routine cost limits (RCL). 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and provides an exemption to the limits for "New Providers." The issue in dispute in this appeal is whether the Provider is entitled to a new provider exemption under 42 C.F.R. §413.30(e) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Covenant Shores is a continuing care retirement center administered by Covenant Retirement Communities West on behalf of the Board of Benevolence of the Evangelical Covenant Church. Covenant Shores consists of both independent living units and a health care center. The health care center is known as the Covenant Shores Health Care

Center (Provider). A SNF provider is required by state law to have a state issued Certificate of Need (CON) to authorize operations of the facility. Covenant Shores purchased its CON for the 51 bed facility from another operator, the Wisely Home. Covenant Shores entered into an agreement under section 1866 of the Social Security Act to participate in the Medicare program as a skilled nursing facility on September 4, 1997. On April 23, 1998, the Provider prepared a written request for an exemption to the SNF RCL for the cost reporting period ended January 31, 1998. The following timeline provides the dates that are significant in this dispute:

April 23, 1998 – Provider submits its exemption request to Health Care Service Corporation, the fiscal intermediary of record at the time.

August 24, 1998 - AdminaStar (Intermediary) replaces Health Care Service Corporation as the fiscal intermediary.

March 23, 1999 - AdminaStar receives the Provider's request and supporting documentation.

April 8, 1999 - AdminaStar forwards the request with its favorable recommendation to CMS.

April 13, 1999 - CMS receives AdminaStar's package.

June 29, 1999 - CMS advises AdminaStar that the Provider has not submitted complete documentation to support its original April 23, 1998 request for an exemption and requests the proper completion of responses to the list of questions specified in Provider Reimbursement Manual (PRM) §2533.1, a copy of the contract with Wesley Home to operate 51 beds, and documentation explaining the use/non-use of the Certificate of Need (CON) rights acquired from Wesley Home between June 3, 1993 and July 4, 1997. CMS' request includes a 45-day limit for submission of the information.

July 8, 1999 - AdminaStar notifies the Provider of CMS' response.

July 15, 1999 - Provider requests an explanation of where their responses were incomplete and refers AdminaStar to Exhibit 3 of its CON which contains the Wesley Home contract.

August 27, 1999 - Provider reiterates its confusion regarding why CMS believes that it responded incorrectly to questions in §2533.1 and provides estimated time budgets to account for the non-use of CON rights between the CON approval and start of Provider's operations.

September 20, 1999 - Provider requests that the package be resubmitted to CMS.

September 30, 1999 - AdminaStar forwards the additional information to CMS.

January 5, 2000 - CMS denies the Provider's initial request (dated April 23, 1998).

Although CMS' June 29, 1999 response initially requested information for three areas, it is undisputed that the sole remaining issue affecting this appeal is whether the Provider supplied a complete and timely response to the narrow question of establishing that its bed rights were not used at some other location in the interim from the Provider's purchase (June 3, 1993) to the point at which the Provider placed them in service (July 4, 1997).

PARTIES' CONTENTIONS:

The Provider's contentions relate to the completeness of its response to the SNF New Provider Exemption Request questions in PRM-1 Section 2531.1, Exhibit B (Intermediary Exhibit 1-15) regarding the use/non-use of the rights to the beds (the CON) the Provider purchased. The Provider acknowledges that the checklist of questions requires information regarding the provider from whom the beds were purchased. However, the Provider contends that the Intermediary's checklist asked for information for only the three years prior to the establishment of the skilled nursing facility requesting the exemption; i.e. from June 3, 1993 to July 4, 1997. The Provider argues that, since the beds were not used during the prior three years, no information related to the prior owner of the beds was required. The Provider argues further that PRM-1 Section 2533.1 states that there is a three-year look-back period to determine a provider's qualification for new provider exemption status. The Provider contends that all responses and the requests to resubmit the exemption request were timely filed within 180 days of the NPRs for each fiscal period. When it filed its second submission on September 20, 1999, the information submitted was complete; therefore, the Intermediary and CMS should have based their decisions on its content. The Provider further contends that any submission of additional information after September 20, 1999 was the result of the continuously unreasonable rejection by CMS of the documentation necessary to prove the non-use of the beds during the three years prior to the licensing of the Provider.

The Intermediary argues that PRM-1 Section 2533.1 requires that an incomplete exemption request be denied by the Intermediary, and the Intermediary is to instruct the provider that it has 45 days from the Intermediary's denial to resubmit the exemption request with all the required documentation. The Intermediary contends that its July 8, 1999 letter advised the Provider of the manual's 45-day requirement. Because the Provider's subsequent submissions were beyond the 45-day limit, the Provider's request was incomplete. Consequently, the Intermediary contends its denial was appropriate.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at the hearing, finds and concludes that CMS' denial of the

Provider's request for an exemption to the routine cost limits for the skilled nursing facility was improper and that the Provider's request should be granted on the merits.

The single issue offered for the Board's consideration is the adequacy of the information supplied by the Provider to support the operational disposition (use/non-use) of the beds purchased from Wesley Home during the period from their purchase (June 3, 1993) to the date that the Provider placed them in use (July 4, 1997). To assess the adequacy of the information, the Board examined the Provider's submission and the other evidence available within the record. The Board's examination of the Provider's initial submission indicated that it was improperly processed between the original and subsequent Intermediaries. Despite the process breakdown, the submission appeared to be complete in its original form, and neither intermediary listed anything that the Provider failed to supply. Indeed, the new intermediary, AdminaStar Federal, gave the Provider a favorable recommendation when it forwarded the request to CMS on April 8, 1999. The Board concludes that CMS' subsequent request for additional information regarding CMS' questions were matters of interpretation rather than completeness. Further, the original submission included persuasive evidence that the beds were not in use from June 3, 1993 to July 4, 197. The Board concludes that where, as here, an exemption request is complete, the 45-day rule is not applicable, and a request for additional clarification from CMS should not disqualify the Provider. The Board finds further that such a request, in itself, does not make the Provider's application incomplete.

The Board concludes that the evidence presented in the Provider's original application was sufficient to establish that the beds were not in use during the period at issue. To the extent that the prior use of the beds was determinative of the merits, the Provider's request for an exemption from the routine cost limits should be granted.

DECISION AND ORDER:

CMS' denial of the Provider's request for an exemption to the routine cost limits for skilled nursing facilities was improper. The Provider's request should be granted on the merits.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Martin W. Hoover, Jr., Esquire
Anjali Mulchandani-West

FOR THE BOARD:

DATE: June 10, 2005

Suzanne Cochran, Esquire
Chairperson