PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D1

PROVIDER -
Rush Presbyterian - St. Luke=s Medical Center, Chicago, IL

Provider No. 14-5335

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ AdminiStar Federal, Inc.

DATE OF HEARING-
May 9, 2000

Cost Reporting Period Ended -
June 30, 1995

CASE NO. 99-1249

CASE NO. 97-2385

INDEX

ISSUE:

Is the Provider entitled to an exception to the skilled nursing facility routine service cost limits for fiscal year ending 1995?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rush Presbyterian-St. Luke's Medical Center (AProvider≅) operates a 176-bed skilled nursing facility (ASNF≅) named the Johnson R. Bowman Health Center for the Elderly. All personnel working in the SNF are Provider employees, and all costs associated with the SNF are included in the Provider=s cost report. The Provider and its sub-unit SNF are located in Chicago, Illinois.

On March 23, 1998, the Provider submitted a timely request for an exception to Medicare=s SNF routine service cost limits applicable to its fiscal year ending June 30, 1995. The Provider explained that its request did not attempt to justify variations between its 1994 and 1995 indirect costs because its 1994 cost report was in the process of being reopened. See Exhibit P-1 at 6.

AdminiStar Federal, Inc (AIntermediary≅) reviewed the Provider=s request and noted that the comparisons between 1994 and 1995 had not been performed, nor had other required analyses and calculations. On that basis, the Intermediary denied the exception request and sent a letter to the Provider on June 15, 1998, giving the Provider 45 days to submit a complete request.

On August 11, 1998, the Intermediary received the Provider=s response to its June 15, 1998 request for a complete exceptions package. On this same date, the Intermediary sent a letter back to the Provider explaining that its denial of the Provider=s 1995 exception request was final because the information received was incomplete, and because the information was not received within the requisite 45 days.

On February 5, 1999, the Provider appealed the Intermediary=s denial to the Provider Reimbursement Review Board (ABoard≅) pursuant to 42 C.F.R. ээ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $658,000.[1]

The Provider was represented by Jeffrey A. Lovitky, Attorney at Law. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

[1] Intermediary=s Position Paper at 5. Provider=s Position Paper at 2.

The Provider contends that its March 23, 1998 submission satisfies all of the program=s requirements for an initial exception request as specified in the Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1≅) ∋ 2534.10. Accordingly, the Intermediary=s denial was improper.[2]

The Provider explains that the Intermediary, in its denial letter dated June 15, 1998, cited five deficiencies with its exception request. The Provider asserts, however, that each of the alleged deficiencies is without merit, as follows:[3]

1. The Intermediary alleges that the Provider failed to submit a variance analysis between its 1994 and 1995 costs. The Intermediary maintains that this comparison is required by HCFA Pub. 15-1 ∋ 2534.11, which states in part:

> [i]f nursing hours per day in any classification differ by more than 25 percent and/or any individual per diem cost differs by more than 20 percent, the cost report and documentation must be reviewed by the Intermediary as though the request was an initial request described in 2534.10. In addition, the provider must justify the causes for these substantial changes as they relate to patient care.

HCFA Pub. 15-1 ∋ 2534.11.

In response, the Provider explains that the exception request submitted on March 23, 1998, specifically noted that the Provider's cost report for 1994 had been reopened by HCFA, and that it was not then possible to obtain finalized cost report data for that reporting period.[4] Since a meaningful variance analysis could not be performed at that time, the Provider advised that it would submit the appropriate comparisons and justifications as soon as the revised Notice of Program Reimbursement (ANPR≅) for fiscal year 1994 became available.[5]

Moreover, the Provider explains that the requirement to justify any variances applies only to Asubstantial changes≅ in costs. HCFA Pub. 15-1 ∋ 2534.11. A substantial change is defined as any cost variance from the prior fiscal year

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[2] Provider=s Post Hearing Brief at 4.

[3] Provider=s Post Hearing Brief at 17. See also Exhibit P-4.

[4] See Provider=s Exception Request at 6.

[5] Transcript (ATr.≅) at 29.

exceeding 20 percent for individual per diem costs. And, the Health Care Financing Administration (AHCFA≅) has further established a threshold of $2.00 per day in defining when a change from a prior year's cost is substantial.

With respect to the subject cost reporting period, the only costs varying more than 20 percent from the prior fiscal year were in Cafeteria, Nursing Administration, and Employee Health and Welfare. However, the variances in Cafeteria and Nursing Administration were less than $2.00 per day.[6] As such, no requirement existed for providing any justification for cost variances with respect to these cost categories.

The variance in Employee Health and Welfare appears to exceed the $2.00 per day and the 20 percent threshold. Id. However, Employee Health and Welfare costs for 1994, as reflected in the exception request, were substantially understated. When the revised 1994 figures are included in the request the variance was actually less than 20 percent. Accordingly, the Provider argues that it was not required to perform the variance analysis sought by the Intermediary--any such analysis would have been meaningless given the reopening of the 1994 cost report, and there were no "substantial changes" between 1994 and 1995 costs.[7]

2. The Intermediary alleges that the March 23, 1998 exception request was deficient because it failed to exclude capital-related costs from the average per diem computed for each routine service cost center pursuant to HCFA Pub. 15-1 ə 2534.5.B. However, testimony elicited at the hearing shows that capital-related costs were excluded from these computations.[8]

3. The Intermediary alleges that the March 23, 1998 request was deficient because it failed to segregate direct costs, and productive and non-productive nursing hours applicable to aides, orderlies, and other personnel from the LPN column. The Provider argues, however, that Exhibit 5 to the subject request contains a complete breakdown of direct costs by various employee classifications. Additionally, the exhibit contains a detailed breakdown of non-labor direct costs. Exhibit 6 to the request contains a detailed breakdown of productive and non-productive nursing personnel hours. In sum, Exhibits 5 and 6 to the March 23, 1998 request present the information requested by the Intermediary in exactly the format prescribed by HCFA Pub. 15-1 ə 2534.10. Accordingly, there is no basis

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[6] Provider=s Exception Request at Schedule 1.

[7] Tr. at 106-108.

[8] Tr. at 39, 76, and 108.

to the Intermediary's contention that this information was omitted from the Provider's request.[9]

4. The Intermediary alleges that the Provider=s request failed to separately identify routine non-nursing direct costs, i.e., Aother direct costs.≅ With respect to this matter, the Provider refers to HCFA Pub. 15-1 э 2534.10, which states in part: A[i]n addition, separately identify the routine non-nursing direct cost, such as drugs and medical supplies, and for purposes of comparison to the peer group, compare these costs to the peer group amount for these cost centers.≅ Id. And respectively, the Provider argues that other direct costs were identified in summary form on Schedule I to its exception request. Also, a detailed breakout supporting these costs is contained in Exhibit 5 to the request. Therefore, these costs were fully detailed in the request as required by program instructions.[10]

5. The Intermediary alleges that the subject request failed to quantify the exception amount for each category of relief sought as required by HCFA Pub. 15-1 э 2534.10.A. In response, the Provider asserts that Schedules 1 and 3 to the exception request contain a detailed breakdown of the various categories of cost for purposes of justifying the exception request. The amount of relief is separately stated for each category as prescribed by the manual. As such, there is no merit to the Intermediary's argument that it failed to separately quantify each category of relief requested.[11]

The Provider contends that even though it met all of the documentation requirements pertaining to an initial exception request, it was not actually required to do so. The Provider asserts that its exception request for 1995 should have been treated as a continuing/repeat request which has documentation requirements that are far less extensive than those of an initial request. And, since the Provider met the documentation requirements for an initial request, as argued above, it clearly satisfied the less extensive requirements for a continuing request.[12]

The Provider asserts that the Intermediary itself conceded that its fiscal year 1995 exception request should have been treated as a continuing/repeat request. In a letter to HCFA dated June 15, 1998, the Intermediary states:

> [t]he exception request for fiscal year ended June 30, 1995, was

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9 Tr. at 40.

10 Tr. at 43.

11 Tr. at 83.

12 Provider=s Position Paper at 6. Provider=s Post Hearing Brief at 6.

> reviewed in accordance with PRM-1, ∋ 2530, Transmittal No. 378. The fiscal Intermediary has employed the methodology utilized by HCFA to compute the SNF exception amount, specifically PRM-1, ∋ 2534.11, for continuing/repeat exception requests.

Intermediary Letter, June 15, 1998 (emphasis added).[13]

The Provider also asserts that the only deficiencies stated in the Intermediary's June 15, 1998 letter which would be applicable to repeat exception requests are: (1) failure to perform a variance analysis with respect to substantial changes in costs between 1994 and 1995; and, (2) the alleged exclusion of capital costs. All of the remaining deficiencies alleged by the Intermediary simply do not apply to repeat requests. Accordingly, the Provider's March 23, 1998 exception request clearly met the lesser standard applicable to repeat requests if, as argued above, it also satisfied the requirements for an initial request. Compare the requirements of HCFA Pub. 15-1 ∋ 2534.10 and HCFA Pub. 15-1 ∋ 2534.11.

Notwithstanding, the Provider contends that it complied with the Intermediary=s directive and resubmitted its exception request within the requisite 45 days.[14] The Provider asserts that the Intermediary should not have rejected its August 6, 1998 resubmission as being untimely for the following reasons:

First, the Intermediary began its 45 day count on June 24, 1998. This is the date the Intermediary contends the Provider received its June 15, 1998 letter regarding this matter. The Provider asserts, however, that there is no evidence to support this Intermediary contention and, in fact, the best evidence shows that the Provider received the Intermediary=s resubmission request after June 24, 1998.

Specifically, the Intermediary's letter dated June 15, 1998, states in pertinent part: A[b]ased on the deficiencies noted above, we are hereby denying your exception request. In accordance with PRM 15-1, Section 2531.A.2, you will have forty-five days from receipt of this rejection to re-submit this exception request, with all of the required documentation.≅ Id. (Emphasis added). Moreover, in its letter dated August 11, 1998, the Intermediary states: A[a]ccording to my records, the request was sent via UPS, and was received on June 24, 1998, by your office." Id.[15] The Provider argues, however, that it has made several requests for copies of the Arecords≅ cited by the Intermediary in support of its assertion that the June 15, 1998 letter was received on June

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[13] Exhibit P-2.

[14] Provider=s Post Hearing Brief at 7.

[15] Exhibit P-1

24, 1998.[16] However, no such records have been produced.

The Provider explains that it has done everything within its power to establish the date upon which it received the June 15, 1998 letter. In part, it caused the issuance of a subpoena directed to the United Parcel Service for copies of any delivery records. However, United Parcel Service responded by stating that such records have been destroyed.[17]

Conversely, the Provider=s witness testified before the Board that he recalled a distinct sense of relief that he had met the deadline established by the Intermediary's June 15, 1998 letter. He further testified that he typically submitted such documents at least one week in advance of the due date. The witness believed that the supplemental information was timely received by the Intermediary on August 11, 1998. Presumably, the witness would not have held this belief had the Provider received the Intermediary=s June 15, 1998 denial letter on June 24, 1998.

Next, the Provider asserts that its resubmission should not have been rejected as untimely because HCFA, not the Intermediary, had denial authority over its March 23, 1998 request.[18] Since HCFA did not authorize the denial of the Provider=s request until August 14, 1998, the resubmission received by the Intermediary on August 11, 1998 was clearly timely.[19]

The Provider explains that intermediary authority regarding SNF exception requests has been fully set forth in a variety of Federal Register notices.[20] On June 1, 1979, HCFA issued a final rule which stated: A[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 will make a recommendation on the Provider's request to HCFA, which will make the decision.≅ 44 FR 31802, June 1, 1979 (emphasis added).

The regulations in effect when the Provider submitted its exception request on March 23, 1998, were essentially identical to the Federal Register notice, stating:

> [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

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16 Exhibits P-11 and P-12.

17 Exhibit P-22.

18 Provider=s Post Hearing Brief at 9.

19 Exhibit P-8.

20 Provider=s Post Hearing Brief at 12.

> 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.

42 C.F.R. ə 413.30 (emphasis added).

The Provider acknowledges that the 1979 rules were substantially changed after the submission of its exception request. On August 5, 1999, HCFA issued a final rule amending 42 C.F.R. ə 413.30(c). This new rule, which became effective on September 7, 1999, provided in pertinent part:

> [t]he intermediary makes the final determination on the SNF request, and notifies the SNF of its determination within ninety 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.

64 FR 42610, August 5, 1999.

Accordingly, the Intermediary's authority to deny exception requests did not become effective until September 7, 1999. Prior to that date, Intermediaries could only recommend that an exception request be denied by HCFA. Therefore, the Intermediary lacked authority to deny the Provider's resubmitted exception request dated August 6, 1998.

The Provider also asserts that this interpretation is consistent with the instructions provided by HCFA to the Intermediary in this case. In a facsimile letter dated June 18, 1998, HCFA specifically advised the Intermediary that it would make the final determination on the Provider's exception request.[21] Further, by letter dated August 14, 1998, HCFA stated that the Provider should be given an additional 45 days in which to resubmit its exception request. HCFA's August 14, 1998 letter further stated that the request should again be forwarded by the Intermediary to HCFA for a final determination, if the Provider submits additional supporting documentation.[22] As such, HCFA advised the Intermediary on at least two occasions that it would make the final determination on the Provider's request.

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[21] Exhibit P-5.

[22] Exhibit P-8.

The Provider cites the Administrator=s decision in LAC/USC Medical Center v. Blue Cross and Blue Shield, Admin. Dec., April 2, 1991, Medicare & Medicaid Guide (CCH) & 39,158, finding that the Board lacked jurisdiction over a provider's appeal of an exception request when HCFA failed to render a decision on that request. Respectively, the Provider argues that the Intermediary lacked authority to issue a final denial determination in the instant case. And, since no such determination was ever rendered by HCFA in connection with the Provider's August 6, 1998 resubmission, this case must be remanded to HCFA for a final determination on its merits. The last reason the Provider believes its resubmission was not untimely is because it was placed in the hands of a courier on August 10, 1998. The Provider asserts that even assuming it received the Intermediary's denial letter on June 24, 1998, the 45 day period would have elapsed on August 8, 1998. However, August 8, 1998, fell on a Saturday. Therefore, applying the well-established rule that the expiration date must be deemed to have occurred on the next business day, the Provider was obligated to submit the requested information on August 10, 1998. As noted above, the Provider submitted the supplemental information requested by the Intermediary on August 10, 1998, via Federal Express. Therefore, its resubmission was timely.[23]

The Provider argues that it is the date of submission, as opposed to the date of receipt, which is dispositive on the timeliness issue. Specifically, the Intermediary's June 15, 1998 denial letter stated: A[y]ou will have 45 days from receipt of this rejection to resubmit this exception request with all of the required documentation.≅ Id. (Emphasis added). The Intermediary could have requested that the supplemental data be received within 45 days, however, the Intermediary stipulated otherwise.

The Provider maintains that its position regarding this matter is consistent with the Board=s decision in St. Joseph Hospital v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D27, March 9, 1999, Medicare & Medicaid Guide (CCH) & 80,167, rev'd, HCFA Admin., May 7, 1999, Medicare & Medicaid Guide (CCH) & 80,214. In that case, the Board considered whether the requirement for submission of an exception within 180 days of the NPR required actual receipt within that period. The Board held that the Provider was required merely to dispatch the document within the 180 day period. The Board further opined that it would apply the common law "mailbox rule" in determining whether a submission was timely made. This rule states that a formal submission is deemed to occur upon its dispatch, even though the item may not actually be received until some time later. See also Hurley Medical Center v. Blue Cross and Blue Shield Association/Health Care Service Corporation, PRRB Dec. No. 98-D62, June 4, 1998, Medicare & Medicaid Guide (CCH) & 80,000, rev=d and rem=d., HCFA Admin., August 7, 1998, Medicare & Medicaid Guide (CCH) & 80,058, rem=d., HCFA Admin., January 8, 1999, Medicare & Medicaid Guide (CCH) & 80,156, decl=d rev., HCFA Admin., July 9, 1999, where the Board held that the provider=s submission was adequate because it made a good

[23] Exhibit P-16.

faith effort to obtain an exception in a timely manner as apposed to a lackluster attempt.[24]

Finally, the Provider contends that its August 6, 1998 resubmission was complete.[25] As discussed above, the Provider maintains that its initial request, dated March 23, 1998, was itself a complete exception request. Accordingly, the Provider argues there can be no doubt that the March 23, 1998 request, as supplemented by its submission dated August 6, 1998, was also complete. The Provider explains that the information it furnished through its letter dated August 6, 1998 was essentially a restatement of the information contained in the initial request. The data was merely reorganized to comply with the prescribed format outlined by the Intermediary in its June 15, 1998 letter.

The Provider adds that the Intermediary does not seem to argue that the resubmitted exception request should be rejected as incomplete. The Intermediary's legal representative stated to the Board:

> [w]e don't think that the Board has the authority to actually adjudicate the exception request. If it makes the decision that the June 15th request for information was appropriate and that the request dated August 6th but received August 11th was still timely, then the remedy is to kind of freeze the clock back to August of 1998 and give the Provider the opportunity, or give them another forty-five days from the date of whenever that decision becomes final to complete the record.

Tr. at 18.

Accordingly, the Provider asserts that its resubmission dated August 6, 1998, should not be rejected as incomplete. Rather, the Provider argues that it should be given additional time to submit any supplemental information the Intermediary may want.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it properly denied the Provider=s request for an exception to the routine service cost limits.[26] The Intermediary asserts that the Provider=s initial submission was incomplete under the standards of an initial request or a repeat request, and that the Provider=s re-submission was untimely and also incomplete.

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[24] Provider=s Position Paper at 12-13.

[25] Provider=s Post Hearing Brief at 11.

[26] Intermediary Position Paper at 6.

The Intermediary contends that it properly treated the Provider=s fiscal year 1995 exception request as an initial request because the Provider did not certify that there had been no change in case mix or circumstances that could reduce the amount of its exception.[27] The Intermediary cites program instructions at HCFA Pub. 15-1 ∋ 2534.3.B.3, which state:

> Repeat Requests. XIf a provider has been granted an exception for a prior cost reporting period and is currently requesting an exception for the same circumstances, see ∋2534.11 for the documentation required. The provider must certify in writing that there has been no change in case mix or circumstances which could reduce the amount of the exception.

HCFA Pub. 15-1 ∋ 2534.3.B.3 (emphasis added).

The Intermediary also explains that a repeat request would not have been evident since the Provider did not submit the requisite comparisons. Program instructions at HCFA Pub. 15-1 ∋ 2534.11- Continuing/Repeating Requests for Atypical Services or Items, state:

> [a]fter HCFA has approved an initial exception, the Intermediary performs the following analyses on requests for the current cost reporting period as compared to the previous cost reporting period when an exception was granted.

HCFA Pub. 15-1 ∋ 2534.11.

Thus, in order for the Provider=s request to be considered a repeat request, comparisons between its fiscal year 1993 and 1995 operations should have been submitted. These comparisons would have been required since the Provider=s exception request for its 1994 fiscal year had not yet been granted. Notably, the 1993 and 1995 comparisons were never submitted.

The Intermediary asserts that even if the required comparisons had been submitted there were significant variances that would have precluded the 1995 request from qualifying as a continuing/repeating request. The Provider explains in the Introduction to its 1995 request that there was a variance between its fiscal year 1993 and 1994 operations, and that 1994 and 1995 were comparable. Specifically, the Provider states: A[t]he increase in length of stay during FY 94 was primarily due to the increased acuity that accompanied the sub-acute patients that started to be treated in FY 94. FY 95 shows no significant variance from FY 94.≅ Provider=s Exception Request, Exhibit I-5 at 3.

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[27] Id.

The Intermediary contends that since the Provider=s request was properly found to be an initial request that HCFA Pub. 15-1 ə 2534.3.A.2-General Exception Request Requirements, apply. Respectively, these rules mandate that the Provider=s exception request provide a comparison between its 1994 and 1995 operations. However, the Provider did not furnish this information.

The Provider admittedly stated in the body of its March 23, 1998 request that the comparison of indirect costs had not been submitted because its 1994 cost report was in the process of being reopened.[28] Notably, the manual does not mandate that comparisons be based upon audited or re-audited and reopened data. Thus, the Provider's reason for failing to submit the necessary data for 1994 is without merit, and its request was properly found incomplete.

The Intermediary contends that its final denial of the Provider=s exception request was proper since the Provider failed to resubmit its request within 45 days as required by HCFA Pub. 15-1 ə 253l.1.B.3, which states:[29]

> [i]f the provider submits an incomplete exception request, the request is to be denied by the intermediary, and the intermediary is to instruct the provider that it has 45 days from the date of the intermediary's denial to resubmit the exception request, with all the required documentation. If at the end of the 45 days, the intermediary does not receive all supporting documentation, the intermediary denies the request.

HCFA Pub. 15-1 ə 253l.1.B.3 (emphasis added).

The Intermediary asserts that the manual is clear, in that, the Provider had 45 days from the date of the denial to submit the required documents. It is also clear that the denial letter was issued on June 15, 1998, via United Parcel Service.[30] Accordingly, the Provider=s response to the denial letter dated August 6, 1998, and received by the Intermediary on August 11, 1998, was not received within the 45 day period.

The Intermediary rejects the Provider=s argument that the 45 day period should begin upon the Provider's receipt of the denial and end upon the Provider's dispatch of the requested documentation. The Intermediary argues that the dates used to calculate the 45 day period should be consistent, meaning that the dates used should both be the dates Asent≅ or the dates Areceived.≅ The 45 day period according to the manual noted above should begin upon the dispatch of the letter from the Intermediary, June 15, 1998, and end upon the dispatch of the

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[28] See Exhibit P-1 at 6.

[29] Intermediary=s Position Paper at 8. Exhibit I-6.

[30] See Exhibit P-2.

Provider=s documentation, August 10, 1998, which is using both sent dates.[31] Thus, the Provider did not submit any additional documentation until 56 days after the denial letter was sent.

The Intermediary also asserts that even if the dates of receipt are used the Provider was still beyond the 45 day limit. The Intermediary explains that the Provider received its June 15, 1998 denial letter on June 24, 1998, and received the Provider=s response on August 11, 1998. Thus, 48 days had passed.

The Intermediary notes, however, that using receipt dates is not correct. In University Medical Center of Southern Nevada v. Blue Cross and Blue Shield Insurance Company, Admin. Dec., May 20, 1999, Medicare & Medicaid Guide (CCH) & 80,215, the Administrator states: Athe regulations are internally consistent because both the date of notice and the date of filing are based on the mailed or postmarked date.≅ Id.[32] The Intermediary asserts, therefore, that proving that the Provider received its June 15, 1998 letter on June 24,1998 is irrelevant.

Notwithstanding, the Intermediary also contends that the additional information submitted by the Provider on August 11, 1998 was inadequate. The Intermediary explains that pursuant to HCFA Pub. 15-1 э 2531.1.B.3, the Provider was required to resubmit its exception request with all the required documentation. The documentation received was not, however, a resubmission. Rather, the Provider submitted some additional documentation and explanations.[33] And, as explained on page 2 of the August 11, 1998 final denial letter, there were several inadequacies with this information.[34]

Finally, in response to Board questions, the Intermediary asserts that it was authorized by HCFA to deny the Provider=s request based upon its incompleteness.[35] The Intermediary explains that during the subject period HCFA retained authority to review an intermediary=s recommendation and make the decision on the amount of relief, if any, to be granted a provider. However, according to the Provider Reimbursement Manual, HCFA=s role comes into play only after an intermediary makes the decision that a request is complete.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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31 See Exhibits I-1 and I-8.

32 Exhibit I-7.

33 See Exhibit I-8.

34 Exhibit I-2.

35 Intermediary=s Post Hearing Brief at 5. Tr. at 96 and 120.

1. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30 et seq.	-	Limitations on Reimbursable Costs

2. Program Instructions-Provider Reimbursement Manual-Part I (HCFA-Pub.15-1):

§ 2531 et seq.	-	Provider Requests Regarding Applicability of Cost Limits
§ 2534 et seq.	-	Request for Exception to SNF Cost Limits

3. Case Law:

LAC/USC Medical Center v. Blue Cross and Blue Shield, Admin. Dec., April 2, 1991, Medicare & Medicaid Guide (CCH) & 39,158.

St. Joseph Hospital v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D27, March 9, 1999, Medicare & Medicaid Guide (CCH) & 80,167, rev'd, HCFA Admin., May 7, 1999, Medicare & Medicaid Guide (CCH) & 80,214.

Hurley Medical Center v. Blue Cross and Blue Shield Association/Health Care Service Corporation, PRRB Dec. No. 98-D62, June 4, 1998, Medicare & Medicaid Guide (CCH) & 80,000, rev=d and rem=d., HCFA Admin., August 7, 1998, Medicare & Medicaid Guide (CCH) & 80,058, rem=d., HCFA Admin., January 8, 1999, Medicare & Medicaid Guide (CCH) & 80,156, decl=d rev., HCFA Admin., July 9, 1999.

University Medical Center of Southern Nevada v. Blue Cross and Blue Shield Insurance Company, Admin. Dec., May 20, 1999, Medicare & Medicaid Guide (CCH) & 80,215.

4. Other:

44 FR 31802, June 1, 1979.

64 FR 42610, August 5, 1999.

Intermediary Letter, June 15, 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post-hearing submissions, finds and concludes as follows:

The Provider requested an exception to Medicare=s routine service cost limits for its cost reporting period ended June 30, 1995. The Provider=s request was timely made within 180 days of the pertinent NPR as required by 42 C.F.R. ə 413.30.

The basis of the Provider=s request was higher than usual costs resulting from atypical nursing services. The Provider had requested and was granted an exception to the cost limits for several cost reporting periods prior to the subject 1995 reporting period, also based upon the atypical nursing services cause.

In a letter dated August 6, 1998, the Provider furnished the Intermediary with cost report data and analyses the Intermediary found to be lacking from the Provider=s 1995 request. This supplemental information along with the Provider=s initial request submission are part of the record at Provider=s Exhibit List at 1 and 6.

On August 11, 1998, the Intermediary denied the Provider=s request. This decision was based upon the Intermediary=s findings that the Provider=s August 6, 1998 submission was not filed timely and was incomplete.

The Intermediary=s denial, however, was improper. Regulations in effect during the applicable period do not give the Intermediary authority to either grant or deny an exception request. Rather, the pertinent regulation, 42 C.F.R. ə 413.30, requires intermediaries to make a recommendation to HCFA regarding provider exception requests, and for HCFA to render a final decision. Respectively, the Board finds that HCFA never rendered a decision either granting or denying the subject request and, therefore, finds that the Board is precluded from rendering a decision based upon the arguments presented herein.

In conclusion, the Board finds that HCFA must review the Provider=s request and render a final decision. HCFA=s decision must either deny the Provider=s request or establish the amount of the exception should one be granted. Moreover, HCFA=s decision should be based upon the cost report data and analyses furnished in the record to this case which includes the Provider=s initial exception request submission dated March 23, 1998, and the Provider=s supplemental submission dated August 6, 1998.

The Board acknowledges that 42 C.F.R. ə 413.30 was eventually revised to delegate to all intermediaries the authority for granting and denying provider exception requests. This rule also appears to implement the 45 day rule for the re-submission of exception requests that was relied upon by the Intermediary in denying the Provider=s 1995 request on the basis of timeliness. Nevertheless, the record shows that this revision to the regulations was not effective until September 7, 1999, which means it is not applicable to the instant case.

Finally, the Board acknowledges but rejects the Intermediary=s proposition that the Provider be

afforded 45 more days to perfect its exception request if its denial is rejected. The Board believes the Intermediary properly requested a re-submission of data from the Provider, and that the Provider responded to that request in a manner it determined appropriate.

DECISION AND ORDER:

The Intermediary was not authorized to deny the Provider=s request for an exception to the SNF routine service cost limits. The Intermediary=s denial is rejected, and the Provider=s request is remanded to HCFA for a decision based upon its merits.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: October 31, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman