PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D83

PROVIDER -St. Mary's Medical Center
Long Beach, CA

Provider No. 05-0191

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
July 27, 1998

Cost Reporting Period Ended -
June 30, 1989

CASE NO. 92-1569

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ISSUE:

Was the Provider's request for an adjustment to the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") limits for the fiscal year ended ("FYE") June 30, 1989 timely?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Medical Center ("Provider") is a general short term hospital located in Long Beach, California. The Provider requested an average length of stay ("ALOS") adjustment to its TEFRA limits for its FYE June 30, 1989. The Health Care Financing Administration ("HCFA") denied the Provider's request because it determined the request was not timely filed. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement effect for all of the years at issue is approximately $249,307.[1]

The Provider received its Notice of Program Reimbursement ("NPR") for FYE 1989 on September 25, 1991. Their cost for that year exceeded their TEFRA limits. During the audit, the Provider had verbally requested an adjustment for ALOS.[2] Just prior to the exit conference for FYE 1989, the Provider had received ALOS adjustments for its three previous fiscal years. During the exit conference, the Provider again verbally requested that Mutual of Omaha ("Intermediary") grant an ALOS adjustment for FYE 1989.[3] On March 23, 1992, 180 days after the date of the FYE 1989 NPR, the Provider mailed a written request for an ALOS adjustment to its TEFRA limits.[4] The Intermediary acknowledged receipt on March 27, 1992, and requested additional information from the Provider.[5] By letter dated October 1, 1992, the Provider submitted the additional information that had been requested by the Intermediary.[6]

On January 28, 1993, the Intermediary issued an NPR correction incorporating the ALOS TEFRA limit adjustment requested by the Provider.[7] On March 4, 1994, HCFA directed that

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1 See Provider Position Paper at 2.

2 See Provider Exhibit 3, ¶ 4.

3 Id., ¶ 4.

4 See Provider Exhibit 5.

5 See Provider Exhibit 7.

6 See Provider Exhibit 8.

7 See Intermediary Position Paper at 2.

the ALOS adjustment be denied.[8] HCFA indicated that the Provider's October 1, 1992 letter was the exception request and it was not filed within 180 days of the original NPR, issued on September 25, 1991.[9] On June 27, 1994, the Intermediary issued an NPR correction removing the ALOS adjustment.[10]

The Provider sent the Intermediary a copy of its March 23, 1992 letter requesting the adjustment on July 6, 1994.[11] Based on this new information the Intermediary issued an NPR correction dated July 7, 1994 allowing the ALOS adjustment.[12]

By letter dated August 30, 1994, HCFA reaffirmed its prior determination that the request was untimely. HCFA indicated that it was not enough for the Provider's request merely to have been mailed within 180 days of the NPR but it actually had to have been received by the Intermediary (evidenced by a received stamp) within 180 days of the NPR.[13]

The Provider was represented by Lloyd A. Bookman, Esquire, and Jon P. Neustadter, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Byron Lampert, Senior Consultant, of Mutual of Omaha.

PROVIDER'S CONTENTIONS:

The Provider contends that under the regulation and manual provisions in effect during the relevant time period, the only guidance afforded providers was to have "made" a request for an adjustment to the intermediary within 180 days of the date on the NPR. The Provider points out that there is no statute, regulation, HCFA Ruling, manual provision, program memorandum, intermediary letter, or any other formal or informal guidance to the provider community or this Provider in particular, suggesting directly or indirectly that a request for an adjustment to the TEFRA limits must be "received" by an intermediary on or before the 180th day after the date of the NPR. Rather, the regulation is at best ambiguous and the Provider contends that mailing an adjustment request on the 180th day fully complies with the regulation. The Provider also indicates that the Intermediary and HCFA have interpreted the regulation inconsistently and that HCFA has interpreted similar provisions as allowing the

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8 See Provider Exhibit 9.

9 Id.

10 See Intermediary Position Paper at 2.

11 See Provider Exhibit 10.

12 See Intermediary Position Paper at 2-3.

13 See Provider Exhibit 11 at 1.

date of mailing to control timeliness. The Provider also contends that HCFA's rejection of its request was arbitrary and capricious and contrary to Medicare law.[14]

The Provider points out that no deadline for provider requests is set in the statute at 42 U.S.C. § 1395ww(b). The regulation setting forth the timeliness rule was issued as an interim final rule on September 30, 1982. See 47 Fed. Reg. 43282. There was no explanation of the timeliness rule in the preamble. The regulation merely states that the " hospital must make a request for an exemption or exception to its fiscal intermediary no later than 180 days from the date on the intermediary's notice of program reimbursement." See id. at 43288. In two other preambles to the final version of the rule, HCFA did not indicate any interpretation or elaborate on the use of the term "made."

The Provider points out that it was not until June 2, 1995, in a proposed regulation, that HCFA informed anyone that to have "made" an adjustment request is to have it received at the intermediary. See 60 Fed. Reg. 29202, 29245 (June 2, 1995). HCFA altered the language of the regulation to state that "[t]he hospital's request must be received by the hospital's fiscal intermediary's no later than 180 days after the date on the intermediary's notice of program reimbursement . . . ." 60 Fed. Reg. 45778, 45849-50 (September 1, 1995).

The Provider indicates that the preamble admits that intermediaries have been inconsistently applying the pre-1995 version of the regulation. It states that "use of the word 'made' in § 413.40(e)(1) has resulted in varying interpretations of the timely filing requirement by hospitals and their fiscal intermediaries." See 60 Fed. Reg. at 45840 (emphasis added). The Provider also presented affidavits to the effect that intermediaries have accepted TEFRA requests mailed within the 180 period after the NPR.[15]

There is no guidance of any kind that would lead a provider to assume the request had to be received by the intermediary. In fact, the Provider points out that the word "made" in Black's Law Dictionary 950 (6th ed. 1990) means "filed." The word filed has been interpreted by the Secretary and HCFA to mean date of mailing. See 42 C.F.R. § 405.1801(a). In addition, HCFA had interpreted the word made to mean the date of mailing in the reopening regulation. See Irendell Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina, HCFA Administrator, April 24, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,263 ("Irendell"). The Provider indicates that the date of mailing rule is the more common rule governing, see 42 C.F.R. §§ 1801(a) and 405.1841, and thus to impose a much more draconian rule required HCFA to so indicate in writing. The Provider also points out that HCFA has used the word "received" in other rules concerning timeliness. See 42

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[14] The Provider also indicates that even if the request had to be received it made two verbal requests and the regulation does not specify that the requests had to be in writing.

[15] See Provider Exhibits 14 and 15.

C.F.R.
§§ 412.256(a)(2), 412.273(a)(2), 1801(a), Provider Reimbursement Manual, Part II (HCFA Pub. 15-II) §102.3 and Medicare Intermediary Manual, Part II (HCFA Pub. 13-2) § 2231.2. The failure to use the word indicates it did not intend it. The Provider requests that the Board resolve the issue in its favor considering the ambiguity and the consequences for the Provider should its request not be allowed to even be considered.

The Provider also asserts that the 1995 changes were not a clarification but a substantive change which should not be applied retroactively. Again the Provider points out that the word made has been previously interpreted to mean mailing rather than date of receipt with regard to reopening of cost reports. See Iredell, supra. Even if the date of receipt had been understood by HCFA, it appears that neither the Provider community nor intermediaries were aware of the rule. Should the Board find that the rule was new and substantive, case law supports the conclusion that the rule cannot be applied retroactively. In Pocatello Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, HCFA Administrator, September 6, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,987, where the HCFA Administrator upheld a date of receipt rule, there was existing guidance and actual notice of the rule in the Provider community. Finally, the Provider asserts that it has presented evidence that the rule has not been consistently applied, and such inconsistent action by other government agencies has been determined to be arbitrary and capricious and resulted in those rules being set aside. See Hooper v. National Transportation Safety Board, 841 F.2d 1150, 1151 (D.C. Cir. 1988).

The Provider also asserts that its oral requests were received within the 180 day period and are acceptable because the regulation does not require a written request from the Provider.

For all of the above reasons the Provider seeks to have the HCFA denial for untimeliness reversed and its request considered on the merits.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's denial of the Provider's request was proper because it was not filed within 180 days of the NPR.

The Intermediary notes that the regulation is absolute about the timing of the request and provides that:

> a hospital may request an exemption from, or exception or adjustment 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 program reimbursement . . . .

42 C.F.R. § 413.40(e)

The Intermediary states that HCFA has consistently interpreted the word "made" to mean "received by the fiscal intermediary" since the original regulation was promulgated. 47 Fed. Reg. 43282 (September 30, 1982). The Intermediary states that a provider is given ample opportunity to file an exception request.

The Intermediary does not believe it "received" the March 23, 1992 letter requesting an ALOS adjustment on the date it was dated. The Intermediary refers to HCFA's position in its August 30, 1994 letter which states that "[i]t is not conceivable that a copy of a one page letter drafted on the 180th day [after the NPR] in a state different from the intermediary's and sent to an address other than the intermediary's address was received within 180 days . . ."[16] The Intermediary indicates that it was not able to locate the original letter in its files, which upon receipt would have been marked and/or evidenced by a date stamp. The Provider has not presented an adequate explanation as to the mail service utilized, and/or why there is no indication that it was sent certified mail (with return receipt requested). The Intermediary also points out that the Provider did not have a facsimile machine until June 1, 1994, therefore, it was not received via facsimile. The Intermediary also indicates that any verbal request should be disregarded because it is HCFA's policy that verbal inquiries are not considered requests.

The Intermediary asserts that HCFA's denial should be sustained because the Provider has not met its burden of proof to substantiate that its request for adjustment was received by the Intermediary within 180 days of the NPR.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)	-	Reasonable Cost
§ 1395rr(b)(7)	-	Medicare Coverage of End Stage Renal Disease Patients
§ 1395ww(b)	-	Rate of Increase in Target Amounts for Inpatient Hospital Services

2. Regulation - 42 C.F.R.:

§ 405.1801 et.seq.	-	Introduction
§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.256(a)(2)	-	

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16 See Intermediary Exhibit 6.

§ 412.273(a)(2) -

§ 413.40(e)[1987] - Hospital Requests Regarding Applicability of the Rate of Increase Ceiling

§ 413.40(e)(1)[1995] - Timing of Application

§ 413.40(e)(2)[1995] - Intermediary Recommendation

§ 413.40(e)(4)[1995] - Notification and Review

3. Program Instructions

a. Medicare Intermediary Manual (HCFA Pub. 13-2):

§ 2231.2 - Provider is No Longer Participating in Medicare and Not Participating in Medicaid

b. Provider Reimbursement Manual (HCFA Pub. 15-II):

§ 102.3 - Changing of Cost Reporting Periods

4. Cases:

Hooper v. National Transportation Safety Board, 841 F.2d 1150 (D.C. Cir. 1988).

Irendell Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina, HCFA Administrator, April 24, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,263.

Pocatello Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, HCFA Administrator, September 6, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,987.

5. Other:

47 Fed. Reg. 43282 (September 30, 1982).

60 Fed. Reg. 29202 (June 2, 1995).

60 Fed. Reg. 45778 (September 1, 1995).

Black's Law Dictionary 950 (6th ed. 1990).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, finds and concludes as follows:

The Board finds and concludes that the Provider properly applied 42 C.F.R. § 413.40 et. seq. Thus, the Provider "made" its request for an appeal once it placed the request in the U.S. mail. This initiated a chain of irreversible events once the request was placed in the hands of a legally recognized agent, the United States Post Office. The regulation at 42 C.F.R. § 413.40 (1987) specifically states:

> (e) Hospital requests 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 program reimbursement. The intermediary will notify the hospital of HCFA's decision. The time required for HCFA to review the exception request is considered good cause for the granting of an extension of the time limit to apply for review by the Provider Reimbursement Review Board, as specified in
> § 405.1841(b) of this chapter. HCFA's decision is subject to review under Subpart R of Part 405 of this chapter.

Id. (emphasis added).

The Board concludes that the text of the regulation at 42 C.F.R. § 413.40(e) does not expressly state that a TEFRA exception request must be received by the Intermediary within 180 days from the Notice of Program Reimbursement. Id. Rather, the regulation specifies that "the hospital request must be made to its fiscal intermediary no later than 180 days from the date on the intermediary's notice of program reimbursement." The Board opines that "made"means that a provider must initiate its exception request by mailing or by other delivery method, on or before the 180-day limitation period. The regulatory language is void of any reference requiring that an intermediary must actually receive the exception request prior to the 180 day deadline. Accordingly, the Provider's tender of its request to the Intermediary, employing the U.S. Post Office on March 23, 1992 was timely submitted.

The Board also reasons that there is no way for an exception applicant to use all time allotted to it by the regulation if it must depend on an intermediary's actual receipt of an exception submission. When or how an intermediary receives or documents its receipt of an item could

vary among intermediaries due to modification of internal mail control procedures. The Board concludes that a standard which employs the United States Postal Service or other recognized means of delivery that requires an item to be date stamped or postmarked the day it is accepted for delivery is a fair and equitable means to document the tender of TEFRA exception requests by applicants.

The Board also avers that in ruling as to whether exception requests mailed or otherwise submitted for delivery on or before the last day of the 180 day limitation period are timely, HCFA is not deprived of the time it has to perform its statutory obligation to approve or deny a request. See 42 U.S.C. § 1395rr(b)(7). The Board opines that the statutory sixty day limitation period would not begin to run until an exception request is "filed." Id. With the exception of the regulations at 42 C.F.R. § 405.1801(a) governing submissions to the Board, the plain meaning of the term 'filed' with respect to submitting documents to an adjudicatory body, is "received," e.g., filed with the clerk of the court. Accordingly, the Board finds its interpretation of the regulation consistent with the statute in that it does not deny HCFA the statutory time period to which it is entitled for reviewing TEFRA exception requests.

The Board finds that the Intermediary's use of the regulation at 42 C.F.R. § 413.40(e)(1) - (e)(4) [1995] is not relevant to the case at hand. The cost report before the Board was calendar year ended 1989. The 1989 regulation applies, not the 1995 revision.

DECISION AND ORDER:

The Provider timely filed its TEFRA exception request. The Board remands the case to the Intermediary to review the case on its merits. The Intermediary's determination is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire

Date of Decision: August 26, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman