PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D41

PROVIDER -
Story County Hospital
Nevada, Iowa

Provider No. 16-0088

vs.

INTERMEDIARY -
Wellmark, Inc.

DATE OF HEARING-
September 23, 1998

Cost Reporting Period Ended -
June 30, 1993

CASE NO. 96-2199

INDEX

ISSUE:[1]

(1) Did the Intermediary, in the course of considering the Provider's request for a Medicare Dependent Hospital (MDH) volume adjustment, have jurisdiction to waive compliance with the applicable time requirement and to grant the Provider a one-day extension of time?

(2) If so, did the circumstances in this case merit such a waiver and extension?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Story County Hospital ("Provider") is a Medicare -dependent small rural hospital located in Nevada, Iowa. By letter dated November 16, 1995,[2] the Provider pursuant to the statutory provisions of 42 U.S.C. § 1395ww(d)(5)(G) requested a volume adjustment for the fiscal year ended June 30, 1993. By letter dated January 26, 1996,[3] Wellmark, Inc. ("Intermediary"), doing business as Blue Cross and Blue Shield of Iowa, denied the request as untimely.

The denial letter cited the implementing regulation, 42 C.F.R. § 412.108(d)(2), which requires submission of the request within 180 days after the date on the Intermediary's Notice of Program Reimbursement ("NPR") for the year in question. The request for adjustment in this case was sent by the Provider, and received by the Intermediary, by fax, on November 16, 1995.[4] That
date was 181 days after the date on the NPR, May 19, 1995. In short, the request was submitted one day late.

By letter dated March 15, 1996,[5] the Provider asked the Intermediary to reconsider the denial. This reconsideration request did not dispute that the request had been received after the 180 day deadline.[6] The letter advised that the Provider had misunderstood the requirement to be

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1 See joint stipulation dated September 18, 1998.

2 Provider Exhibit 2.

3 Provider Exhibit 3.

4 The Intermediary acknowledges that a second copy of the request was received by mail on November 17, 1995. See Provider Exhibit 14, items 21 & 23.

5 Provider Exhibit 4.

6 Id.

six months, rather than 180 days, and had submitted the request within six months. On April 4, 1996,[7] the Intermediary denied reconsideration.

By letter dated May 21, 1996,[8] the Intermediary acknowledged that, were it not for the timeliness question, the requested adjustment was appropriate and would have been allowed. The letter further advised that the Intermediary was checking with the Health Care Financing Administration ("HCFA") to ensure that they concur with our decision." Id.

By letter dated June 10, 1996,[9] the Intermediary inquired of HCFA as follows:

> [w]e denied the reconsideration request as the original request was not received within the 180 day timeframe. We did not feel that it was within our authority to grant this request even though it was only one day late. We are asking your opinion on how this situation should be handled. We feel that it is likely if this goes before the Provider Reimbursement Review Board (PRRB) that the PRRB will find in favor of the provider....

Id.

By letter dated September 12, 1996,[10] HCFA responded:

> [t]he 180 day limit for requesting volume decline adjustments is consistent with our requirement for hospitals that are paid by Medicare under the provisions of the Tax Equity and Fiscal Responsibility Act. These hospitals are required to request exceptions to their payment limits within 180 days of their NPRs. The limit is firmly set so that even a request with a postmark that is within the limit will be denied unless the request is received by their fiscal intermediary within the 180 days.
>
> Likewise, the hospital must assure that the fiscal intermediary receives its volume reduction adjustment request within the specified time of 180 days, not within 6 months. As stated above, the limit is firm and allows ample time for providers to prepare and submit the necessary information to request the additional payment. We concur with your decision ....

HCFA Letter dated September 12, 1996, Provider Exhibit 8.

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[7] Provider Exhibit 5.

[8] Provider Exhibit 6.

[9] Provider Exhibit 7.

[10] Provider Exhibit 8.

On June 7, 1996, the Provider timely requested a hearing before the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. § 405.1835-.1841. A hearing was held before the Board on September 23, 1998. The amount of reimbursement in controversy is $297,326.[11]

The Provider was represented by Craig F. Graziano, Esquire, of Dickinson, Mackaman, Tyler, and Hagen, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider asserts that the Intermediary believes that it lacks authority to allow a volume adjustment when the request for adjustment is received more than 180 days after the date on the NPR. The Provider points out that the Intermediary acknowledged that, were it not for the timeliness question, the requested adjustment was appropriate and would have been allowed.[12] The Provider disputes HCFA's claim[13] that the time limit in question is "firm". The Provider contends instead that the Intermediary, under appropriate oversight from HCFA, has jurisdiction or authority to grant an extension of time if the circumstances merit. In addition, the Provider invokes the law of "excusable neglect" to contend that the circumstances in this case do merit an extension of time.

The Provider contends that the regulatory provision at 42 C.F.R. § 412.108(d)(2), providing that a Medicare-dependent small rural hospital must submit a volume adjustment request within 180 days after the date on the NPR, is not jurisdictional. The Provider further contends that in an appropriate case, under appropriate oversight from HCFA, the Intermediary has authority to waive technical compliance and to accept a request received out of time.

The Provider rejects HCFA's assertion that the 180 day requirement is firm. The Provider contends that the statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii), is silent insofar as time is concerned. The Provider argues that the regulatory time requirement at issue here, 42 C.F.R. § 412.108(d)(2), is like the regulatory time requirement at issue in Cooper v. Bell, 628 F.2d 1208 (9th Cir. 1980) ("Cooper"). The Provider contends that the underlying statute in Cooper, like the underlying statute in the present case, was "silent" as to the time period within which an initial administrative filing was to be made. Id. at 1212. The Provider points out that the court held that a time requirement inserted by regulation was " an administrative procedural requirement," "subject to equitable extension in appropriate cases," not a "rigid jurisdictional requirement." Id. at 1213.

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[11] Provider Exhibits 6, 7, & 12.

[12] See Provider Exhibits 6, 7.

[13] See Provider Exhibit 8.

The Provider argues that in Zipes v. Trans World Airlines, Inc., 455 U.S. 385 (1982), the Supreme Court went further, holding that even Congressionally prescribed time limits sometimes operate as statutes of limitations, subject to extension in appropriate cases, and not as jurisdictional prerequisites. Focusing on the "underlying Congressional policy," id. at 393, the Provider notes that the Court chose the former, more lenient approach in that instance, because it would "honor the remedial purpose of the legislation . . . ." Id. at 398.

The Provider asserts that there is little doubt about the remedial purpose of the legislation here. The Provider points out that in the words of the Senate Finance Committee, the Congressional intent in authorizing volume adjustments was to take account of the unique circumstances that rural hospitals confront, "including their vulnerability to substantial variations in occupancy rates."[14] The Provider also notes that in the words of a House Conference Committee, the idea is "to fully compensate the [rural] hospital for the fixed costs it incurs and for the reasonable cost of maintenance of core staff and services.[15]

Based on the above, it is the Provider's position that the 180 day rule in the regulation is an administrative or procedural rule rather than a jurisdictional prerequisite. Continuing, the Provider cites American Farm Lines v. Black Ball Freight Service, 397 U.S. 532 (1970), for the proposition that "it is always within the discretion of a court or an administrative agency to relax or modify its procedural rules adopted for the orderly transaction of business before it when in a given case the ends of justice require it." Id. The Provider also notes the Supreme Court's decision in Schacht v. United States, 398 U.S. 58 (1970), ("Schacht"), as an example of a case in which strict compliance with a non-statutory time limit was waived and an untimely filing permitted. The Provider concludes the first portion of its argument by stating that the Intermediary had the authority it thought it lacked and, if the circumstances warranted, could similarly have waived compliance with the time limit and accepted the request of out of time.

The Provider points out that a conclusion that the Intermediary has authority to waive compliance does not mean, of course, that compliance necessarily should be waived. On the contrary, it remains to be considered whether the circumstances here justify a waiver. The Provider references Justice Harlan in Schacht at 67, that the appropriate standard to be applied is one of "good cause" or "excusable neglect". Id. The Provider contends that the tardy filing in this case was the result of excusable neglect and should therefore have been accepted rather than rejected. Citing Pioneer Investment Services Co. v. Brunswick Associates Limited Partnership, 507 U.S. 380 (1993), ("Pioneer"), and Lorenzen v.

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[14] Sen. Rep. No. 98-23, 98th Cong., 1st Sess., at 54 (March 11, 1983), reprinted in 1983-2 U.S. Code Cong. & Admin. News at 194.

[15] House Conf. Rep. No. 98-47, 98th Cong., 1st Sess., at 194 (March 24, 1983), reprinted in 1983-2 U.S. Code Cong. & Admin. News at 484.

Employees Retirement Plan, 896 F.2d 228 (7th Cir. 1990), the Provider contends that the doctrine of excusable neglect grants a reprieve to out-of-time filings that were delayed by "neglect." The Provider contends that the word "neglect" in this context has its ordinary meaning - that a matter has been given little attention or respect or, closer to the point, has been left undone or unattended to, especially through carelessness. Relying on its interpretation of the above cases, the Provider contends that the doctrine permits acceptance of late filings caused by inadvertence, mistake or carelessness, as well as by intervening circumstances beyond a party's control. Pioneer at 388. The Provider contends that sanctions should be proportional to the gravity of the wrongdoing they punish, that if a mistake is slight, non-prejudicial, easily understandable, etc., then forfeiture is an excessive sanction. The Provider contends that errors of this type are largely self-deterring and therefore not a grave social problem calling for draconian measures.

Turning its attention to the particular circumstances in this case, the Provider contends that compliance with the time limit should have been waived, and the request for adjustment accepted out of time, because: (i) the request was received only one day late; (ii) the request was made in good faith; (iii) the request was prepared by personnel who are not trained as lawyers; (iv) there are plausible reasons why these personnel acquired an erroneous understanding about the time limit in question; (v) the NPR did not give the Provider any notice or "prompt" about the time limit in question; (vi) accepting the request would honor the remedial purpose of the legislation; and (vii) accepting the request would not prejudice any party. The Provider contends that the Intermediary abused its discretion in concluding otherwise.

With respect to circumstance (iv) above , the Provider contends that its accountant's mental substitution of "six months" for "180 days" was plausible or understandable and therefore, in combination with the other relevant circumstances, excusable.[16] Citing Walls v. Merit Systems Protection Board, 29 F.3d 1578 (Fed. Cir. 1994), the Provider contends that it demonstrated due diligence and ordinary prudence in submitting the request within the time period as construed by it.

The Provider argues that it is not unusual for a rule to start the clock upon receipt of a mailed document by its addressee, or to allow several additional days for delivery by mail, thus effectively adding the one day here at issue. In closely analogous contexts, the Provider points out that HCFA has itself issued discrepant directives on this kind of an issue, indicating at one place that the clock starts with the date of the notice or the date of mailing, and at another, that the clock starts with the date of receipt. The Provider contends that these discrepancies illustrate the ease with which a misconstruction can arise. The Provider notes several examples in its Position Paper where HCFA uses the phrases, “within 180 days”, “within 180 days from the date of this NPR”, “no later than the 180th calendar day following

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[16] See Tr. at 34-35.

the date of the provider's . . . receipt of the NPR", and "no later than the 180th calendar day following the date of receipt by [the provider]." See Provider Position Paper at 21, fn. 10.

With respect to circumstance (v) above, the Provider contends that neither the NPR nor the enclosures with it contained any notice or "prompt" about the procedural requirements for requesting a volume adjustment, including, most importantly, the time limit in question.[17] Citing Fairmont Hospital v. Blue Cross and Blue Shield Association, HCFA Administrator's Decision, May 6, 1994, ("Fairmont"), Medicare & Medicaid Guide (CCH), ¶42,435, the Provider contends that HCFA has itself recognized that absence of such notice or prompt can serve to excuse strict compliance with a time limit. The Provider notes that in Fairmont, the Board dismissed a request for hearing pursuant to 42 C.F.R. §§ 405.1801-.1889 because the request for hearing had not been filed within 180 days of the denial of a request for exception pursuant to 42 C.F.R. § 413.30. Reversing, the Administrator held that the denial of the request for exception failed to trigger the 180-day period for requesting a hearing because it contained no information regarding the provider's appeal rights and did not state that the provider was required to request a hearing before the Board within 180 days.

The Provider rejects the Intermediary's argument that the Administrator's decision in Pocatello Regional Medical Center v. Blue Cross and Blue Shield Assn., September 6, 1996, CCH Medicare & Medicaid Guide ¶ 44,987,, ("Pocatello")[18] is support for denying the Provider's request. The Provider points out that the Administrator stressed repeatedly in upholding the intermediary's denial of the exception there, the hospital had "actual notice" of the time requirement based on the correspondence directed to it (emphasis added). The Provider argues that the Administrator's decisions in Fairmont and Pocatello are thus consistent with one another in that both stress the importance of actual notice in the relevant correspondence. Because no such notice was given in the instant case, the Provider contends that Fairmont rather than Pocatello provides the proper guidance here.

In conclusion, it is the Provider's position that there would be no prejudice to anyone were its request to be accepted. As the Intermediary admits, the money sought by the Provider is money that Congress intended it to have. Based on the above arguments, the Provider respectfully asks the Board to decide if the Intermediary, in the course of considering its request for a Medicare Dependent Hospital (MDH) volume adjustment, had jurisdiction to waive compliance with the applicable time requirement and to grant the Provider a one-day extension of time. And, if so, did the circumstances in this case merit such a waiver and extension?

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[17] Tr. at 47.

[18] Intermediary Exhibit I-8.

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the denial of a request for a MDH volume corridor payment adjustment due to a decline in inpatient discharges was made in accordance with Medicare Regulation 42 C.F.R. § 412.108(d) and 42 C.F.R. § 412.92(e).

The Intermediary refers to the regulation at section 412.108(d):

> "Additional payments to hospitals experiencing a significant volume decrease. (1) HCFA provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period ... (2) To qualify for a Payment adjustment on the basis of a decrease in discharges,-a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement..." (emphasis added).

42 C.F.R. § 412.108(d).

The Intermediary contends that the 180 day limit for requesting volume decline adjustments is consistent with the HCFA's requirement for hospitals that are paid by Medicare under the provisions of the Tax Equity and Fiscal Responsibility Act. The Intermediary further contends that these hospitals are required to request exceptions to their payment limits within 180 days of their NPRs. It is the Intermediary's position that the limit is firmly set so that even a request with a postmark date that is within the limit will be denied unless the request is received by the fiscal intermediary within the 180 days.

Likewise, the Intermediary asserts that a hospital must assure that the intermediary receives its volume reduction adjustment request within the specified time of 180 days, not within six months. As stated above, the limit is firm and allows ample time for providers to prepare and submit the necessary information to request the additional payment

The Intermediary notes the Provider's argument that its understanding of the filing requirements was that they were based on being received within six months, since on all other time limits, Medicare operates in terms of complete months. The Intermediary disagrees. The Intermediary notes several examples in its Position Paper where the Program Instructions and regulations specifically stipulate days, and not months, when discussing time frames for information submission.[19]

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[19] Intermediary Position Paper at 6-7.

The Intermediary cites the HCFA Administrator's Decision in, Pocatello , which it contends is a case similar to the issue at hand in that the Provider failed to comply with the regulatory submission deadline. The Intermediary maintains that the governing regulation and HCFA guidelines require facilities to submit requests within 180 days of notification, and in this case, Pocatello, the intermediary received the provider's request on the 181st day. The Administrator reversed the Board and held that the intermediary properly rejected the provider's exception request for untimeliness.

The Intermediary also points out that Board's decision in Maria Manor Nursing Care Center v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Florida, PRRB Dec. No. 97-D60, May 25, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,263, ("Maria"), dealt with many of the same arguments the Provider is making in the present case, however, it did not get into the "excusable neglect" defense.[20] It is the Intermediary's position that the "regulation does not have room to accept that type of interpretation ["excusable neglect"] or variance."[21]

In conclusion, it is the Intermediary's position that Medicare regulations, in regard to the request for the volume payment adjustment, clearly provide for the denial of the request received after the 180 day deadline. Therefore, the Intermediary requests that the Board affirm its adjustment.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

§1395oo(a)(3)	-	Provider Reimbursement Review Board
§1395ww(d)(5)(G) et seq.	-	Medicare-Dependent Small Rural Hospital

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

§§ 405.1801-.1889	-	Provider Reimbursement Determinations and Appeals
§405.1835(a)	-	Right to Board Hearing

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[20] Tr. at 15; Intermediary Exhibit I-10.

[21] Tr. at 15.

§405.1841(a)	-	Time, Place, Form and Contents of Request for Board Hearing
§412.92 (e)	-	Additional payments to sole community hospitals experiencing a significant volume decrease.
§412.108(d) et seq	-	Special Treatment: Medicare-Dependent Small Rural Hospitals
§413.30	-	Limitations on Reimbursable Costs

3. Legislative History

House Conf. Rep. No. 98-47, 98th Cong., lst Sess., at 194 (March 24, 1983).
Sen. Rep. No. 98-23, 98th Cong., Ist Sess. (March 11, 1983).

4. Cases

American Farm Lines v. Black Ball Freight Service, 397 U.S. 532 (1970).

Pioneer Investment Services Co. v. Brunswick Associates Limited Partnership, 507 U.S. 380 (1993).

Schacht v. United States, 398 U.S. 58 (1970).

Zipes v. Trans World airlines, Inc., 455 U.S. 385 (1982).

Cooper v. Bell, 628 F.2d 1208 (9th Cir. 1980).

Lorenzen v. Employees Retirement Plan, 896 F.2d 228 (7th Cir. 1990).

Walls v. Merit Systems Protection Board, 29 F.3d 1578 (Fed. Cir. 1994).

Fairmont Hospital v. Blue Cross and Blue Shield Assn, HCFA Administrator's Decision, May 6, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,435.

Pocatello Regional Medical Center v. Blue Cross and Blue Shield Assn., HCFA Administrator's Decision, September 6, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,987.

Maria Manor Nursing Care Center v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Florida, PRRB Dec. No. 97-D60, May 25, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,263.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties contentions, evidence presented, the Provider's post hearing brief, and testimony elicited at the hearing, finds and concludes that the Provider's request for a MDH volume corridor payment adjustment due to a decline in inpatient discharges was not timely filed under procedures established in the regulations for requesting a volume adjustment.

The Board finds that the governing regulation at 42 C.F.R. § 412.108(d) sets forth explicit procedures with which a provider must comply in submitting a timely request for additional payments due to a volume decrease. This regulation states that a " a Medicare-dependent, small rural hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement..." In the instant case, the Provider filed its request for a volume adjustment on November 16, 1995,[22] which was 181 days after the date of the applicable NPR issued on May 19, 1995. On January 26, 1996, the Intermediary denied the request as untimely citing the timely filing requirements of 42 C.F.R. § 412.108(d) as its basis.[23] By letter dated September 12, 1996, HCFA affirmed the Intermediary's decision to deny the Provider's request.[24] The Board finds that the Intermediary's action was consistent with the applicable regulations and that the Board is bound by those regulations in the instant case.

In response to alternative arguments put forth by the Provider, the Board finds that it has no basis for treating the Provider's request as the functional equivalent of a Board appeal request which is governed by the regulations at 42 C.F.R. § 405.1841. Regarding the Provider's argument that the personnel hired by it to prepare the request were, "not trained as lawyers," the Board concludes that this argument was not beyond the control of the Provider. Irrespective of the reasonableness or fairness of the Provider's position, the Board does not have the authority to superimpose its regulatory appeal process over the regulatory procedures specifically established for filing requests for volume adjustments.

Regarding the Provider's specific question, as stated in Part 1 of the issue statement, of whether the Intermediary has jurisdiction to waive compliance of the time requirement and grant the Provider a one-day extention, the Board finds that the Intermediary is bound by the

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[22] Provider Exhibit 2.

[23] Provider Exhibit 3.

[24] Provider Exhibit 8.

timeliness procedures established in the regulations for requesting volume adjustments and does not have the authority to waive compliance and grant a one-day extension..

DECISION AND ORDER:

The Provider's request for a volume adjustment was not timely filed. The Intermediary's denial of the Provider's request was consistent with 42 C.F.R. §412.108(d) and 42 C.F.R.§412.92(e).

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (concurring opinion)
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: April 29, 1999

For The Board

Irvin W. Kues
Chairman

Concurring Opinion

I concur with the decision of the majority of the Board, but write to emphasize my concern about the nuances of this case.

Clearly, in my opinion, equity is on the side of the Provider. Unfortunately, the rigid reality of administrative law at the level of the PRRB is not.

This case begs for a forum where equitable principles and appropriately-directed Congressional concern for the viability of essential, small rural hospitals, as evidenced in the Medicare Dependent Hospital volume adjustment legislation, rises above bureaucratic intransigence.

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Henry C. Wessman, Esquire