PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D27

PROVIDER -
North Memorial Health Care
Minneapolis, Minnesota

Provider No.: 24-0001

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
June 28, 2006

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 04-0552

INDEX

ISSUE:

Whether the FY 2000 ambulance cost per trip limits were improperly low because the Intermediary improperly applied the 5.8% outpatient operating cost reduction and the 10% outpatient capital cost reduction to base year costs utilized to calculate those limits.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due 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 portion 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 or PRRB) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

North Memorial Health Care (the Provider) is a voluntary, non-profit, acute care hospital located in Minneapolis, Minnesota that also operates rehabilitation and psychiatric sub-providers, a home health agency, hospice and a hospital-based ambulance service. As part of the final settlement of the Provider's FYE 12/31/2000 cost report, the Intermediary reduced capital-related costs for outpatient hospital services by 10 percent and outpatient operating costs by 5.8 percent. The Provider disagreed with the application of the reduction factors to its ambulance services (which were also subject to cost per trip limits) and filed a timely hearing request with the Board.[1] The amount in controversy is $458,176.[2]

[1] On February 9, 2006, the Board on its own motion requested jurisdictional briefs noting that the Provider on its cost report, neither claimed nor protested the costs which are the subject of this appeal. In its May 3, 2006 response, the Intermediary conceded that

The Provider was represented by David E. Dopf, Esq., of Reed Smith LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.[3]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred when it applied the 5.8% and 10 % reduction factors. The Provider argues that ambulance services have always been treated differently than other outpatient services because they are excluded from the "72 hour rule"[4] under which outpatient services are paid pursuant to an inpatient diagnosis related group (DRG). Also, hospital-based ambulance services are excluded from the outpatient prospective payment system (Outpatient PPS); therefore, the fact that the application of these reductions ended upon the adoption of Outpatient PPS is further evidence that Congress did not intend for them to apply to ambulance services.

The Provider also notes that the 5.8% and 10% reduction factors apply to services at 42 U.S.C. §1395x(s)(2)(A-D), which defines outpatient hospital services. Ambulance services, however, are separately defined at 42 U.S.C.§1395x(s)(7). Accordingly, the 5.8% and 10% reduction factors which apply to outpatient hospital services pursuant to §§1395x(v)(1)(S)(ii) (I and II), do not apply to ambulance services. This is further supported by the fact that 42 U.S.C. §1395x(v)(1)(U), which provides instruction regarding how to calculate the ambulance services cost per trip limit, does not discuss the reduction factors.

The Provider also contends that irrespective of whether ambulance services qualify as outpatient hospital services pursuant to §§1395x(v)(1)(S)(ii)(I and II), the 5.8% and 10% reduction factors should not have been applied in the base year; rather, the Intermediary should have used the Provider's actual costs for the base year to determine the cost per trip limit. Because the reduction factors were applied to the base year costs, the Provider's ambulance trip reimbursement for the subsequent cost periods was understated.

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jurisdiction existed on the basis that the reduction factors at issue were built into the CMS approved software that the Provider used to file the initial cost report. Thus, as the Provider filed its cost report in full compliance with the Secretary's rules and regulations, it may claim dissatisfaction with the application of the reduction factors pursuant to Bethesda Hosp. Assn. v . Bowen, 485 U.S. 399 (1988). Accordingly, the Board hereby finds that it has jurisdiction over this case.

[2] See Provider letter dated September 2, 2005, Intermediary letter dated June 26, 2006.

[3] The parties agreed to adjudicate this case on the record. Additionally, the hearing transcript of the March 3, 2005 telephonic hearing in the PRRB case Decatur County General Hospital v. Riverbend et.al (Case No. 03-0513) has been incorporated into the record with the Intermediary's Supplement Position Paper at Exhibit (Ex. 17). The parties each stated that they relied upon the arguments presented in the Decatur hearing in addition to the arguments presented in the position papers.

[4] See, 42 U.S.C. §1395www(a)(4); 42 C.F.R. §412.2(c)(5).

The Provider explains that 42 U.S.C. §1395x(v)(1)(U), which determines the reasonable cost of ambulance services by establishing a cost per trip limit, is based upon the costs recognized as reasonable in the prior fiscal year. Accordingly, the statute is based on the premise that a base year exists, and what is recognized is the amount determined as "reasonable cost," as opposed to the amount paid for the previous year. Additionally, 42 U.S.C.§1395(x)(v)(1)(A) defines "reasonable cost" as the cost actually "incurred" (as opposed to the Medicare payment after the reduction). Likewise, the statute which makes the reduction itself, §1395x(v)(1)(S)(ii), states that the Secretary should reduce the "reasonable costs" as opposed to making a reduction to obtain the reasonable costs. Moreover, Congress only intended these reductions to apply to outpatient operating costs and capital costs which are now covered by Outpatient PPS. The Provider claims that a recognizable, discrete distinction exists between ambulance services and outpatient services subject to the 5.8% and 10% reduction factors.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the 5.8% and 10% cost reduction provisions of the Social Security Act apply because under 42 U.S.C. §1395(x)(s)(7) patients transported by ambulance (with the exception of patients being transported between hospitals) are outpatients covered under Part B. Although the Intermediary does not dispute the Provider's contention that ambulance services are treated differently from other outpatient services in certain situations, that different treatment alone does not dictate redefining ambulance services as something other than an outpatient service.

Section 1861(v)(1)(S)(ii)(III) of the Social Security Act, which provides for an exception to the cost reduction provisions applicable to the costs of outpatient services provided by critical access hospitals and sole community hospitals does not apply to this Provider. The Intermediary also contends that including the 5.8% and 10% reductions in the calculation of the base year reasonable cost per trip limit was proper.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence presented and the parties' contentions finds that the ambulance services at issue are subject to the 5.8% and 10% reduction factors, but that the reduction factors should not be applied to the base year.

42 U.S.C. §1395x(v)(1)(S)(ii) provides that such reduction factors be applied to outpatient hospital services:

> (I) …in determining the amount of the payments that may be made under this title with respect to all the capital related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this Subchapter . . . by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under Section 1395L(t) of this title is implemented. (emphasis added)

> (II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than capital-related costs of such services) otherwise determined pursuant to section 1395*l*(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1395*l*(t) is implemented (emphasis added).

Pursuant to the Balanced Budget Act of 1997 (42 U.S.C. §1395x(v)(1)(U)), Congress enacted the following cost per trip limit to determine the reasonable cost of ambulance services.

> In determining the reasonable cost of ambulance services . . . provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year . . . increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point.

Additionally, 42 U.S.C. §1395x(s)[5] has seventeen subsections that define medical and other health services. Subsection (7) defines ambulance services as medical and health services. The Board agrees with the Provider that four of the twenty-two subparts (§§A-D) of subsection (2) of 42 U.S.C. §§1395(x)(s) *clearly describe* "outpatient hospital services." However, the Board finds no merit or authority for the Provider's contention that these four subparts *exclusively* define "outpatient hospital services." Thus, the Board

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[5] 42 U.S.C. §1395x(s) states, in relevant part

(s) The term "medical and other health services" means any of the following items or services:

(2) (A) services and supplies…furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians bills;

(B) hospital services… incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangement with them made by a hospital, and

(ii) ordinarily furnished by such hospital…to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services…

(7) ambulance service where the use of other methods or transportation is contraindicated by the individual's condition, but only to the extent provided in regulations.

finds that the ambulance services at issue are subject to the 10% and 5.8% reduction factors.

As further evidence that the ambulance services at issue are outpatient hospital services, (although not covered under Outpatient PPS), 42 U.S.C.§1395l states, in relevant part:

> . . . (t) Prospective payment system for hospital outpatient department services—
>
> (1) Amount of payment
> (B) Definition of covered OPD services
> For purposes of this subsection, the term "covered OPD services"--
> (iv) does not include…ambulance services, for which payment is made under a fee schedule described in section 1395m(k) of this title or section 1395m(L) of this title . . .
> (10) Special rule for ambulance services
> The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1395x(v)(1)(U) of this title or, if applicable, the fee schedule established under 1395m(l) of this title. (emphasis added.)

42 C.F.R. §419.22 states:

> Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system
>
> The following services are not paid for under the hospital outpatient prospective payment system:
>
> (i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or if applicable, the fee schedule under section 1834(L).

Accordingly, the Board finds that the ambulance services at issue are subject to the 5.8% and 10% reduction factors, as they are outpatient hospital services.

Regarding whether the costs recognized as reasonable in the base year should include the application of the 5.8% and 10% reduction factors, the Board agrees with the Provider that the reductions should not be applied to the base year. The Board also agrees with the Provider that 42 U.S.C §1395x(v)(1)(S) and the statutory scheme support the premise that the 5.8% and 10% reductions are made to arrive at reasonable costs.[6]

DECISION AND ORDER:

The Intermediary improperly applied 5.8% outpatient operating cost reduction and 10% outpatient capital cost reduction to base year costs used to calculate the Provider's FY

[6] See also 42 U.S.C. §§1395(x)(v)(1)(A)and (U).

2000 ambulance cost per trip limits. The Board hereby orders the Intermediary to recalculate the ambulance cost per trip limits accordingly and modify its adjustments.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: April 20, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson