# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D44

**PROVIDER -**
Cancer Treatment Center of Tulsa
Tulsa, Oklahoma

Provider No.: 37-0190

**vs.**

**INTERMEDIARY -**
BlueCross BlueShield Association/
BlueCross BlueShield of Oklahoma

**DATE OF HEARING -**
June 17, 2008

Cost Reporting Period Ended –
December 31, 2000

**CASE NO.:** 03-1643

**INDEX**

ISSUE:

Whether the Intermediary properly treated the Provider as an acute care prospective payment system (PPS) facility instead of an excluded cancer hospital.

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. §1395h, 42 C.F.R. §§413.20, 413.24.

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) 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:

Cancer Treatment Center of Tulsa (Provider) is a hospital located in Tulsa, Oklahoma. The Provider offers inpatient and outpatient hospital services for cancer patients. In addition to traditional cancer treatment such as chemotherapy, radiation therapy, and surgery, the Provider offers a wide range of advanced diagnostic and therapeutic procedures, including fluorescence bronchoscopy, high dose rate brachytherapy, photodynamic therapy, and intensity modulated radiation therapy. Additionally, clinical trials and research on new cancer therapies are conducted at the Provider.

On its Medicare cost report for fiscal year ended December 31, 2000 (FYE 2000) submitted to Blue Cross Blue Shield of Oklahoma (Intermediary), the Provider reported type of hospital as "3" (cancer) on line 19 of Worksheet S-2. During its audit of the Provider's FYE 2000 cost report, the Intermediary made adjustments to Worksheet S-2, including an adjustment to change the type of hospital to "1" for general short term hospital. The Intermediary's final determination of the Provider's reimbursement for

inpatient and outpatient hospital services in the audited cost report was based on this adjustment.

The reimbursement impact of the Intermediary's adjustment on inpatient hospital payment for FYE 2000 is estimated to be between $2 and 3 million. For the portion of FYE 2000 subject to outpatient PPS, the difference between the Provider's reasonable costs for outpatient services and the payment amounts under outpatient PPS was approximately $265,000.

The Provider appealed the adjustment to the Board and the appeal met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Christopher L. Crosswhite, Esquire, of Duane Morris, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it correctly identified itself on Worksheet S-2 of its cost report and that it was at all relevant times a cancer specialty hospital. It has consistently filed its annual cost report as a cancer hospital since 1996 and serves only cancer patients.

The Provider contends that it met the relevant regulatory criteria for designation as a cancer hospital in accordance with 42 C.F.R. §412.23(f)(1)(iii) and (iv). It requires the Provider to demonstrate:

> [t]hat the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).

The Provider was and is organized solely for the treatment of and research on cancer, and was in no manner a subunit of an acute general hospital or university-based medical center. Accordingly, the Provider meets this requirement for cancer hospital designation.

According to 42 C.F.R. §412.23(f)(1)(iv), the Provider must show that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD-9-CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.) The Provider also meets this requirement for cancer hospital designation.

The Provider argues that in order to make a correct determination of filing status, the relevant regulation must be viewed in its entirety in such a manner as to lead to a reasonable interpretation and reasonable results. 42 C.F.R. §412.23(f)(1) has four subparts. In response to the Intermediary's position that all of the subparts must be met and that the Provider failed to meet the requirements of subparts (i) and (ii) thereunder,

the Provider argues that it did not exist prior to 1989, as described in subpart (ii), nor did it exist prior to 1983 as referenced in subpart (i) of the code section. However, the Provider met all of the requirements of subparts (iii) and (iv), respectively. Those requirements, and not requirements relating to historical impossibilities, are the relevant criteria for the Provider's situation.

Further, the regulation does not require that the Provider, or any other hospital, meet all of the four subparts; but rather, meeting any of the subparts applicable to the hospital's situation should suffice. There is no language in the regulation that indicates that a hospital must meet (i), (ii), (iii), and (iv); each of such subparts presents an independent idea, and thus, an independent basis for qualifying for the "cancer hospital" filing status. Each subpart is presented as an independent sentence, without "and" connecting the subparts. This wording and structure contrast sharply with the regulations on the exclusion of psychiatric hospitals, children's hospitals, and long-term care hospitals, under which the requirements are connected with "and." See, 42 C.F.R. §§412.23(a), (d), and (e).

Alternatively, the Provider contends that the regulation as interpreted is arbitrary and capricious. The Intermediary's position is based on the first subpart in 42 C.F.R. §412.23(f)(1) concerning recognition as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983. Refusing any new designations of cancer hospitals based on a historical circumstance dating back to 1983 is plainly arbitrary and capricious.[1]

The Provider further contends that the Medicare statute regarding inpatient PPS already provides sufficient authority for exceptions and adjustments to payment under PPS for cancer hospitals other than those on the CMS list. The statute provides the following:

> The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.

42 U.S.C. §1395ww(d)(5)(I)(i).

It was pursuant to the original version of this statutory provision in 1983 that CMS first established regulatory criteria for cancer hospitals, before the Congressional amendments to the statute providing for specific cases not addressed under the regulations for cancer hospitals.[2] Finally, the Provider argues that CMS has failed to comply with the requirements of the Administrative Procedure Act (APA). The Intermediary and CMS apparently take the position that no cancer hospital designations other than the eleven identified on a list on the CMS website may be made. A list on the CMS website does not have the legal authority of a regulation or statute and hardly complies with APA rule-making requirements to provide formal notice and opportunity for comment on substantive agency policies

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[1] See, Intermediary Exhibit 4 at 1.
[2] See, Provider Position Paper at 11.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider filed its cost reports for the 1993 through 1995 and 2003 fiscal year ends as an acute care hospital and for fiscal years 1996 through 2002 as a cancer hospital. However, prior to its first cost report under outpatient PPS, December 31, 2000, it did not matter how a hospital was classified (acute care versus cancer). It was not until outpatient PPS became effective for claims with dates of service on or after July 1, 2000 that it does matter. The Provider never requested and was never approved as an excluded cancer hospital by CMS. The Intermediary is bound by Medicare regulations, including Medicare Regulation 42 C.F.R. §412.23(f), Program Instructions, and Program Memoranda.

The Intermediary further argues that the Provider has not met the requirements of the above regulation and is therefore not entitled to treatment as an excluded cancer hospital. In its preliminary position paper the Provider admitted that it does not meet all the stated criteria at 42 C.F.R. §412.23(f)(1). This Provider is not listed as an excluded cancer hospital on the CMS web site.[3] CMS Central Office has supported the Intermediary's conclusion stating that there are no more certifications of Medicare PPS excluded cancer hospitals; the only mechanism a provider would have to be classified as a cancer hospital would be getting someone in the U.S. Congress to write language for the specific hospital.[4]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and evidence submitted, the Board finds and concludes that the Intermediary properly classified the Provider as an acute care hospital instead of a cancer hospital. The Board finds the statute is clear - all of the requirements at §1886(d)(1)(B)(v) of the Social Security Act of either subsection (II) or (III) must be met in order to qualify as a cancer hospital. Subsections (II) and (III) state as follows:

> (II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), or

[3] See Intermediary Exhibit 3.
[4] See Intermediary Exhibit 4.

> (III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of the enactment of this subclause, is licensed for 162 acute care beds, and that demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E) . . .

The Medicare regulation at 42 C.F.R. §412.23(f) essentially mirrors the above statute. It states:

> (f) *Cancer hospitals—(1) General rule*. Except as provided in paragraph (f)(2) of this section, if a hospital meets the following criteria, it is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after October 1, 1989. A hospital classified after December 19, 1989 is excluded beginning with its first cost reporting beginning after the date of its classification.
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> (i) It was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983.
> (ii) It is classified on or before December 31, 1990, or, if on December 19, 1989, the hospital was located in a State operating a demonstration project under section 1814(b) of the Act, the classification is made on or before December 31, 1991.
> (iii) It demonstrates that the entire facility is organized primarily for treatment of and research on cancer (that is, the facility is not a subunit of an acute general hospital or university-based medical center).
> (iv) It shows that at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease. (The principal diagnosis for this purpose is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital. For the purposes of meeting this definition, only discharges with ICD-9-CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect neoplastic disease.)

(2) Alternative. A hospital that applied for and was denied, on or before December 31, 1990, classification as a cancer hospital under the criteria set forth in paragraph (f)(1) of this section is classified as a cancer hospital and is excluded from the prospective payment systems beginning with its first cost reporting period beginning on or after January 1, 1991, if it meets the criterion set forth in paragraph (f)(1)(i) of this section and the hospital is -

(i) Licensed for fewer than 50 acute care beds as of August 5, 1997;
(ii) Is located in a State that as of December 19, 1989, was not operating a demonstration project under section 1814(b) of the Act; and
(iii) Demonstrates that, for the 4-year period ending on December 31, 1996, at least 50 percent of its total discharges have a principal diagnosis that reflects a finding of neoplastic disease as defined in paragraph (f)(1)(iv) of this section.

While the regulation might arguably be interpreted as allowing a facility to be treated as a cancer hospital if any one of the criteria addressed in the regulation is met, the statute makes clear that all four criteria must be met in order to qualify as a cancer hospital. Furthermore, CMS' official interpretation of the above regulation is stated in the Hospital Manual §3001.9[5] which clearly states that all of the criteria must be met.

Because the statute clearly requires that all four criteria be met, the Provider's arguments regarding failure to comply with APA are moot.

DECISION AND ORDER:

The Intermediary properly required the Provider to meet all of the requirements of 42 C.F.R. §412.23(f) in order to qualify as a cancer hospital. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A. inactive

[5] See Intermediary Exhibit I-5, pp. 19 & 20.

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: September 30, 2008