PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D38

PROVIDER –
Prosser Memorial Hospital
Prosser, Washington

Provider No.: 50-1312

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Noridian Administrative Services

DATE OF HEARING -
March 10, 2011

Cost Reporting Period Ended -
December 31, 2004

CASE NO.: 07-0522

INDEX

ISSUE:

Whether the Intermediary's adjustment to the Provider's ambulance service rates was proper.

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. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & 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 to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The 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 receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 (2008).

In 1997, Congress established the Critical Access Hospital (CAH) program. 42 U.S.C. § 1395i-4. To be designated a CAH, a facility must be a rural hospital located in a State that has established a Medicare rural hospital flexibility program, and must be located more than a 35-mile drive from any other hospital or critical access hospital. 42 U.S.C. § 1395i-4(c)(2)(B). In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24-hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and keep each inpatient for no longer than 96 hours, unless a longer period is required because of inclement weather or other emergency conditions, or a peer review organization (PRO) or other equivalent entity, on request, waives the 96-hour restriction. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. CAHs are paid on a reasonable cost basis, rather than under the prospective payment system.[2] 42 U.S.C. § 1395f(*l*) and 42 U.S.C. § 1395m(g). The regulations governing CAHs are located at 42 C.F.R. §§ 413.70 and 485.601 *et seq*.

[1] FIs and MACs are hereinafter referred to as intermediaries.

[2] A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. For hospital inpatient PPS, payment is made at predetermined, specific rates for each hospital discharge. 42 U.S.C. §1395ww(d) and (g).

Also in 1997, Congress required the Secretary of HHS to establish a national fee schedule for ambulance services, whether provided directly by a supplier or provider or under arrangement with a provider, under Medicare part B through negotiated rulemaking. 42 U.S.C. 1395(*l*).

In 2000, Congress made changes to the payment system for ambulance services furnished by CAHs. 42 U.S.C. § 1395m(*l*)(8). The section provides, in pertinent part:

> *(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES*
>
> *(8) SERVICES FURNISHED BY CRITICAL ACCESS HOSPITALS*
>
> Notwithstanding any other provision of this subsection, the Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished—
>
> (A) by a critical access hospital (as defined in section 1395x(mm)(1) of this title)[3], or
>
> (B) by an entity that is owned and operated by a critical access hospital, but only if the critical access hospital or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such critical access hospital.

42 U.S.C. § 1395m(*l*)(8)

The implementing regulations are found at 42 C.F.R. § 413.70(b)(5), and provide:

> (5) *Costs of ambulance services.*
>
> (i) Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity.
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> (ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the closest provider or supplier of ambulance services are garaged. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.

42 C.F.R. § 413.70(b)(5)(i) and (ii).

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[3]42. U.S.C. § 1395(x)(mm)(1) provides the definition for a CAH as: "(1) The term "critical access hospital" means a facility certified by the Secretary as a critical access hospital under section 1395i–4(e) of this title."

In addition, the regulations at 42 C.F.R. § 414.601 *et seq* establish a fee schedule for the payment of ambulance services. The regulations specify: "[E]xcept for services furnished by certain critical access hospitals (see § 413.70(b)(5) of this chapter), payment for all ambulance services, otherwise previously payable on a reasonable charge basis or retrospective reasonable cost basis, be made under a fee schedule." 42 C.F.R. § 414.601.

The regulations at 42 C.F.R. § 414.605, in pertinent part, provide the following definitions for ambulance services:

> Definitions. As used in this subpart, the following definitions apply to both land and water (hereafter collectively referred to as "ground") ambulance services and to air ambulance services unless otherwise specified:
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> *Advanced life support (ALS) assessment* is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.
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> *Advanced life support (ALS) intervention* means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel.
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> *Advanced life support, level 1 (ALS1)* means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
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> *Advanced life support, level 2 (ALS2)* means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:(1) Manual defibrillation/cardioversion.(2) Endotracheal intubation.(3) Central venous line.(4) Cardiac pacing.(5) Chest decompression.(6) Surgical airway.(7) Intraosseous line.
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> *Advanced life support (ALS) personnel* means an individual trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualifications of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that include being able to administer additional interventions and medications.

> *Basic life support (BLS)* means transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some States is an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.
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> *Emergency response* means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance entity begins as quickly as possible to take the steps necessary to respond to the call.
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> 42 C.F.R. § 414.605

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Prosser Memorial Hospital (Provider) is a Critical Access Hospital (CAH) located in Prosser, Washington. For the cost reporting period ended December 31, 2004, the Provider claimed the actual cost of its ambulance services. Noridian Administrative Services (Intermediary) audited the cost report and determined the Provider did not qualify for cost based reimbursement for the ambulance services because other ambulance services existed within a 35 mile radius of the hospital. The Intermediary adjusted the ambulance service costs by applying the ambulance fee schedule.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841. The Provider was represented by Tim Cooper, Chief Financial Officer, Prosser Memorial Hospital. The Intermediary was represented by James Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that it qualifies for cost based reimbursement for ambulance services because it is the only 911 emergency responder in its service area.[4] The Provider acknowledged that there are other ambulance services which exist within a 35 mile radius of the hospital; however, those ambulance services respond only to 911 emergency calls within their own service area.[5] The Provider further contends that it has been designated by the state as a "Necessary Provider CAH," which does not subject it to the 35 mile ambulance service rule.[6]

The Intermediary responds that the statute and regulations are clear that in order to receive reimbursement on a cost basis, the CAH ambulance service must be more than a 35 mile drive

[4] Provider Position Paper at 2; Transcript at 19.
[5] Provider Position Paper at 2; Transcript at 22 - 29.
[6] Provider's Post-hearing summary at 1.

from the next closest provider or supplier of ambulance services.[7] Neither the statute nor regulations speak to the nature or level of ambulance services, nor the application to a particular ambulance service area.[8] Based on the clear language of the law, the agency has no authority to make exceptions to the 35 mile ambulance service rule.[9] The Provider has conceded that there is another ambulance service within a 35 mile radius. Consequently, the Provider does not qualify for cost reimbursement of its ambulance services.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's adjustment to the Provider's ambulance service rates was proper.

The Board finds the statute at 42 U.S.C. § 1395m(*l*)(8) and the regulation at 42 C.F.R. § 413.70(b)(5) are clear in establishing that ambulance services furnished by CAHs, or entities owned and operated by them, are paid for the services based on reasonable cost, thereby exempting them from the ambulance fee schedule, but only if there is no other ambulance provider or supplier within a 35-mile drive of the CAH. The regulations at 42 C.F.R. § 414.605 define ambulance services to include BLS, ACLS I and ACLS II.

The Provider contends that it is exempt from the 35 mile rule because it has been designated by the State of Washington as a "Necessary Provider" and that it is the only 911 emergency responder in its service area. However, neither the statute nor the regulations contain any exception to the 35 mile rule as to the type, level or particular service area of the provider. It is beyond the Board's authority to grant an exception where there is none specified in the statutory or regulatory language.

In this case, it is undisputed that there are other ambulance companies within 35 miles of the Provider.[10] As such, the Provider does not meet the statutory or regulatory criteria for cost reimbursement for its ambulance services. The Intermediary's adjustment to the Provider's ambulance service rates based on the ambulance fee schedule was proper.

DECISION AND ORDER

The Intermediary's adjustment to the Provider's ambulance service rates was proper. The Intermediary's adjustments are affirmed.

[7] Intermediary Position Paper at 3-4; Tr. at 10-11.
[8] Tr. at 12.
[9] Tr. at 13, Intermediary's Post-hearing brief at 3, Intermediary's Exhibit I-8.
[10] Provider's Final Position Paper Exhibit 3; Intermediary's Exhibits I-2 through I-6; Tr. at 29 - 30.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.
Michael W. Harty

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: JULY 13, 2011