# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

ON-THE-RECORD
98-D71

**PROVIDER** -
St. Mary's Hospital and Medical Center
San Francisco, CA

Provider No. 05-0457

**vs.**

**INTERMEDIARY** -
Blue Cross and Blue Shield Association/
Blue Cross of California

**DATE OF HEARING-**
June 18, 1998

Cost Reporting Period Ended -
June 30, 1990

**CASE NO.** 95-2007

**INDEX**

ISSUE:

Was the Intermediary's refusal to reopen the Provider's cost report an abuse of discretion?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Mary's Hospital and Medical Center ("Provider") is a short term, general service, acute care hospital located in San Francisco, California. The Intermediary settled the Provider's 6/30/90 cost report through the issuance of a Notice of Program Reimbursement dated June 30, 1992.[1] On June 28, 1994, the Provider filed a timely request to reopen the cost report, citing the need to correct a material error.[2] In its request, the Provider stated that it had a different charge structure for inpatients and outpatients, and the outpatient charges should be "grossed-up" to reflect the inpatient charge structure.

The Intermediary denied the Provider's request in a letter dated February 6, 1995.[3] In that letter, the Intermediary commented that the Provider's request appeared to be based on a philosophical issue as opposed to a factual situation, in that the "grossed-up" charges used an imputed figure rather than the actual charges from the Provider's records.

On April 13, 1995, the Provider appealed the Intermediary's denial of the reopening request to the Provider Reimbursement Review Board ("Board").[4] The Board concluded it had jurisdiction over the appeal pursuant to the ruling in State of Oregon, O.B.O. Oregon Health Services v. Bowen, 854 F. 2d 346 (9th Cir. 1988) ("Oregon"). In keeping with Oregon the Board has limited its review of this appeal to the issue of whether the Intermediary's denial of the Provider's reopening request was an abuse of discretion.[5]

The Provider is represented by Thomas P. Knight of Toyon Associates, Inc. The Intermediary's representative is Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary abused its discretion in denying the reopening

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1 Exhibit I-2.

2 Exhibit I-1.

3 Provider Exhibit P-3.

4 Exhibit I-4.

5 See Oregon at 350 and Provider's Amended Position Paper at p. 3-4.

request. Specifically, the Provider contends that (1) it provided the Intermediary with new and material evidence warranting a reopening of the cost report, (2) the cost report contains a clear and obvious error, and (3) the cost report settlement is inconsistent with applicable regulations and instructions regarding the use of charges for apportionment of costs.

The Provider addresses each of the areas as follows:

New and Material Evidence

The Provider's reopening request set forth information regarding the Provider's charge structure for outpatient versus inpatient surgeries and the related anesthesia and supply charges. This evidence indicated that outpatient charges had been set lower than the corresponding inpatient charges even though the location of the services and cost of the services were the same. Such a difference in charge structure caused a distortion in the cost apportionment process whereby more cost was apportioned to inpatient services than to outpatient services.

Clear and Obvious Error

Identification of the inconsistency between inpatient versus outpatient surgery charges demonstrated that there was a clear and obvious error in the cost report. The Provider contends that it set forth what the corrected charges should be to correct the error and provided copies of the applicable source document used to determine the correct charges.

Inconsistency with Regulations and General Instructions

The Provider asserts that the Medicare Program regulations at 42 C.F.R. § 413.53 provide that total allowable costs of a provider will be apportioned between Program beneficiaries and other patients so that the share borne by the Program is based upon actual services received by Program beneficiaries. Sections 2202, 2203, and 2302 of the Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) govern the definition and use of charges as the basis for apportionment of costs. These sections provide that charges should be related, consistently, to the cost of the services and uniformly applied to all patients, whether inpatient or outpatient. Section 2203 of HCFA Pub. 15-1 specifically requires intermediaries to evaluate the providers' charging practice to ascertain whether it results in an equitable basis for apportioning costs.

The Provider points out that its reopening request documented that the charges used to settle the cost report were not uniformly applied to both inpatients and outpatients, and that the charges were not related consistently to the cost of the services rendered. The billed charges were inconsistent with both regulations and instructions regarding the use of charges to apportion costs.

The Provider contends that the Intermediary failed to carry out its responsibility in that it did not perform a review of the Provider's charges to determine if the charges would result in an equitable basis for apportioning cost. Accordingly, the issue, as presented by the Provider, is not a philosophical issue as stated by the Intermediary but indeed is a factual issue. If the Provider's charges are not uniform between inpatients and outpatients, then the charges must be adjusted. The "grossing-up"principle is well established and has been the subject of several Board decisions and court cases.[6] The Provider cites Madison Avenue Hospital v. the Travelers Insurance Company, PRRB Dec. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) ¶ 29,654, declined rev. HCFA Administrator, December 23, 1988; St. Mary's Hospital v. Heckler, 753 F. 2d 1362 (7th Cir. 1985); Tri County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH) ¶ 34,604; and Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 22, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,350, declined rev. HCFA Administrator, December 23, 1988, as cases where there was a finding that a "grossing-up" of charges was required for proper apportionment.

The Provider notes that this same charge "gross-up" issue was heard by the Board for this Provider (prior cost report year) in Case No. 92-0507 on December 5, 1996.[7]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its refusal to reopen was well within the regulatory guidelines. Its determination of charges was based on the Provider's books and records and agrees with the manner in which the Provider filed its own cost report. Therefore, the manipulation of charges by imputing a "gross-up" due to the discounting of outpatient charges would be incorrect. Although the Provider requested a "gross-up" of charges in its reopening request, the Provider did not clearly demonstrate the propriety of those charges in its request for reopening.

The Intermediary contends that it did not abuse its discretion in refusing to reopen the Provider' s cost report. The instructions in HCFA Pub. 15-1 § 2931.2, state that "[w]hether or not an intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, or general instructions". The Provider did not demonstrate that any of these situations which would allow a reopening existed. Therefore, the Intermediary contends that it complied with the regulations and

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6 Provider's Amended Position Paper at p. 7-8.

7 The Board has recently ruled that the Intermediary's adjustment disallowing the Provider's "grossing-up" of its outpatient surgery charges for apportioning purposes was improper. See PRRB Dec. No. 98-D45.

instructions in denying the Provider's reopening request.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

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| § 1395x(v)(1)(A) | - | Reasonable Cost |

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

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|---|---|---|
| § 413.53 | - | Determination of Cost of Services to Beneficiaries |

3. Program Instructions- Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1):

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|---|---|---|
| § 2202 | - | Definitions |
| § 2203 | - | Provider Charge Structure as a Basis for Apportionment |
| § 2302 | - | Definitions |
| § 2931.2 | - | Reopening Final Determination |

4. Cases:

State of Oregon, O.B.O. Oregon Health Services v. Bowen, 854 F. 2d 346 (9th Cir. 1988).

Madison Avenue Hospital v. The Travelers Insurance Company, PRRB Dec. 79-D10, March 5, 1981, Medicare and Medicaid Guide (CCH) ¶ 29,654, declined rev. HCFA Administrator, December 9, 1981.

St. Mary's Hospital Medical Center v. Heckler, 753 F. 2d 1362 (7th Cir. 1985).

Tri-County Hospital v. Heckler, Civ. No. 83-2638, (D.D.C. April 18, 1985), Medicare and Medicaid Guide (CCH) ¶ 34,604.

Glencoe Municipal Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 89-D4, November 22, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,530, declined rev, HCFA Administrator, December 23, 1988.

St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 98-D45, April 24, 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the regulations, manual instructions, facts, parties' contentions, and evidence in the record, finds and concludes that the Intermediary abused its discretion by not reopening the Provider's Medicare cost report for the year ending June 30, 1990.

The Board finds that the Provider has established charges for its outpatient surgery services at a lower level than the corresponding inpatient charges. However, the same surgical suites, staff, equipment, and supplies are used by both inpatients and outpatients. As a result, such a difference in the charge structure would cause a distortion in the cost apportionment process whereby more costs would be apportioned to inpatient services than to outpatient services.

The Board finds that a basic principle of the Medicare Program, as set forth in 42 C.F.R. § 413.53, holds that total allowable costs of a provider will be apportioned between Program beneficiaries and other patients so that the share borne by the Program is based upon actual services received by Program beneficiaries. The apportionment of cost takes place in the Medicare cost report and charges are used to apportion the costs. The Board further finds that Section 2203 of HCFA Pub. 15-1 requires intermediaries to evaluate the providers' charging practice to ascertain whether it results in an equitable basis for apportioning costs.

The Board finds that the Provider's reopening request set forth information regarding the Provider's charge structure for outpatient versus inpatient surgeries. This evidence indicated that outpatient charges had been set lower than the corresponding inpatient charges, even though the location of the services and cost of the services were the same. Thus, the difference in charge structure would result in a distortion of the cost apportionment process, as discussed above.

The Board also notes that the Provider's reopening request cited five other unrelated issues as a possible basis for reopening the June 30, 1990 Medicare cost report. However, the record does not indicate whether the Intermediary considered or responded to these issues.

The Board finds that HCFA Pub. 15-1 § 2931.2 states that a reopening determination will depend upon whether new and material evidence has been submitted, or a clear and obvious error has been made, or the original determination is found to be inconsistent with the law, regulations, or general instructions. In the instant case, the charges used by the Intermediary to settle the cost report were not uniformly applied to both inpatients and outpatients. The billed charges were inconsistent with both the regulations and general instructions regarding the use of charges to apportion costs. Therefore, the Board finds that the Intermediary's actions were not in accordance with existing laws and regulations, and also constituted a clear

and obvious error. In addition, the failure of the Intermediary to address any of the additional issues, presented in the Provider's petition to reopen, clearly indicates that the Intermediary did not consider new and material evidence that may warrant a reopening of the cost report. Based on the above findings, the Board concludes that the Provider is entitled to the requested reopening.

DECISION AND ORDER:

The Intermediary abused its discretion in refusing to reopen the Medicare cost report for the year ended June 30, 1990. The Intermediary is directed to reopen the Medicare cost report and determine if the Provider's "grossed-up" charges result in an equitable basis for apportioning cost.

Board Members Participating:

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

Date of Decision: July 02, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman