PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D101

PROVIDER -Martin Luther King, Jr./
Drew Medical Center
Los Angeles, CA

Provider No. 05-0578

vs.

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

DATE OF HEARING-
September 1, 1998

Cost Reporting Period Ended -
June 30, 1985

CASE NO. 89-0706

INDEX

ISSUE:

Was the Intermediary's determination of the amount of Medicare outlier payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Martin Luther King, Jr./Drew Medical Center ("Provider"), which is located in Los Angeles, California, is a general acute-care hospital owned and operated by the County of Los Angeles. Blue Cross of California ("Intermediary") issued the Provider's Notice of Program Reimbursement ("NPR") for fiscal year 1985, the year under appeal, on August 12, 1988.

The Provider filed an appeal of several issues related to the NPR on February 8, 1989 and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. On November 8, 1993, the Provider added two issues arising from a revised NPR dated May 24, 1993. The Provider has either withdrawn or resolved with the Intermediary all the issues except one. This remaining issue arose from the initial NPR.

The Provider was represented by John R. Hellow, Esq., of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esq., of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider explains that Congress established a special payment mechanism for outlier cases in order to protect hospitals and their patients from the potentially harsh incentives of the Medicare Prospective Payment System. An outlier case is an individual discharge that falls outside the average cost predicted by the applicable diagnosis-related group ("DRG") either because the case is unusually costly or it has a significantly longer than normal length of stay. Pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(i) and (ii), the provision adopted by Congress, the Secretary establishes thresholds for each federal fiscal year for the point at which a specific case qualifies for an additional outlier payment due to unusual length of stay or extraordinary cost. If a case qualifies as a day or cost outlier, the hospital receives an additional payment. In the instant case, the issue involves cost outlier payments only.

The Provider also notes that under the periodic interim payment ("PIP") mechanism, a provider receives flat biweekly payments to approximate the average costs of covered inpatient services during the two-week period. See 42 C.F.R. § 413.64. Throughout the cost reporting period, intermediaries send providers remittance advices. These remittance advices summarize the claims approved by the intermediary by patient and amount of reimbursement due. For a PIP provider, the remittance advice provides notification of the amount of DRG reimbursement due for the claims listed and the amount of outlier payments actually made. During the fiscal year under appeal, the Intermediary sent the Provider remittance advices showing only the total

reimbursement due for each patient claim rather than distinguishing between the DRG amount due and the outlier payment.[1]

The Provider contends that because of problems with the Pricer System, the Intermediary did not pay the full and appropriate amount for cost outlier claims. The Pricer System was used by the Intermediary to calculate payments to providers. The Intermediary sent letters dated December 12, 1986, to other hospitals, indicating that it could not process certain cost outlier requests due to system problems. The Intermediary further stated in this correspondence that, as soon as the problem was corrected, it would give priority to the processing of cost outlier adjustments.[2] The Provider concludes that these letters provide strong evidence in support of its position that the Intermediary failed to process and pay the appropriate amount for the Provider's outlier claims.

The Provider also argues that its documentation pertaining to eight cost outliers is proof of the Intermediary's underpayment. The Provider maintains that it has correctly calculated the cost outlier for these eight claims and compared them with the Intermediary's remittance advices to demonstrate that the Intermediary incorrectly calculated its payments.[3]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is wrong to base its position on the two letters from its Medicare Claims Department. The letters do not say that the Intermediary failed to process certain outlier requests. The Intermediary wrote them in response to a specific provider's inquiry about a systems problem with its claims. The correspondence does not apply to other providers.

The Intermediary also points out that the Provider did not provide documentation for the outlier payments claimed during the cost report audit or when it submitted its preliminary position paper.[4] Thus, without documentation as required by 42 C.F.R. § 413.24 and the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2304, it cannot make a redetermination.

---

1 Provider's Position Paper, pp. 4-5.

2 Provider's Position Paper, Exhibit P-1.

3 Provider's Supplemental Letter, Attachment.

4 Intermediary's Position Paper, p. 6.

CITATION OF LAWS, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. 42 U.S.C.:

§ 1395ww(d)(5)(A)(i) and (ii)	-	Outlier Payments

2. 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.64	-	Payments to Providers, Specific Rules

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

§ 2304	-	Adequacy of Cost Information

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the facts, parties' contentions, and evidence presented finds and concludes as follows:

The Board finds that the underlying disagreement in this case concerns documentation. At the time of their initial arguments on this case, the Intermediary noted that there was no Provider documentation to support the Provider's contention. One year later the Provider supplied documentation on eight patient outlier payments. See Provider's May 14, 1996 supplemental letter. After review of the documentation, the Board finds that the documentation to be acceptable. The Board notes that the Intermediary has had time to review this documentation and that the Intermediary's case rested on lack of documentation.

With regard to the Provider's contention that the Herrick Hospital case is "substantially similar" to the case currently before the Board,[5] the Board finds this case to not be on point.

---

[5] Provider March 20, 1996 letter.

DECISION AND ORDER:

The Intermediary's adjustment is reversed. The Intermediary is to use the Provider's documentation to make an outlier payment for the eight cases.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman