PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D104

PROVIDER -
Los Angeles County NICU/IME Beds
Group Appeal

Provider Nos. Various

vs.

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

DATE OF HEARING-
August 7, 1998

Cost Reporting Period Ended -
June 30, 1991

CASE NO. 94-0284G

INDEX

ISSUE:

Was the Intermediary's inclusion of neonatal intensive care unit ("NICU") beds in the indirect medical education ("IME") calculation proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Martin Luther King, Jr./Drew Medical Center, Harbor/UCLA Medical Center, Olive View Medical Center, and LAC+USC Medical Center, ("Providers") are public general acute care hospitals in Los Angeles County, which have approved medical education programs. As teaching hospitals, the Providers receive additional payments in the form of an adjustment for the IME, pursuant to 42 U.S.C. § 1395ww(d)(5)(B).

The IME payment is made to reimburse providers for the additional use of ancillary services inherent in the training of interns and residents. Among the elements of the calculation of the IME payment is the bed count. Certain types of beds are not be included in the calculation. At issue here is whether the NICU beds are included or excluded in the calculation. The difference in opinion centers on whether NICU beds are newborn bassinets or pediatric ICU beds. Blue Cross of California ("Intermediary") contends that the beds are pediatric ICU beds that must be included in the bed count for the IME calculation. The Providers maintain that the inclusion of these neonatal intensive care beds in the IME calculation was improper and violates 42 C.F.R. § 412.118.

On November 23, 1993, the Providers appealed the issue to the Provider Reimbursement Review Board ("Board") and have met the jurisdictional requirements of 42 C.F.R. § 405.1835-.1841. The amount of Medicare reimbursement in dispute is approximately $832,588.[1]

The Providers were represented by John R. Hellow, Esquire, and Jon P. Neustadter, Esquire, of Hooper, Lundy, & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

BACKGROUND:

The formula for determining the IME adjustment includes the ratio of full time equivalent ("FTE") interns and residents to the number of hospital beds. 42 C.F.R. § 412.118(a)(1), (redesignated § 412.105 (1991), See 56 Fed. Reg. 43241 (Aug. 30, 1991)).

Prior to 1985, the IME regulation, then codified at 42 C.F.R. § 405.477(d)(2), stated that the IME payment would be based on the ratio of FTE interns and residents to beds, without indicating how the number of beds would be determined and without requiring exclusion of

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[1] See Intermediary Position Paper at 1.

any particular category of beds from the calculation. Effective April 29, 1985, this regulation was redesignated to 42 C.F.R. § 412.118, without any change regarding the calculation of the number of beds. 50 Fed. Reg. 12740, 12759 (Mar. 29, 1985) .

Direction as to the bed calculation first appeared in a June 10, 1985 proposed rule concerning changes to the inpatient hospital prospective payment system. See 50 Fed. Reg. 24366 (June 10, 1985). The proposed change to § 412.118(b) was as follows:

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Id.

The discussion regarding indirect medical education in the preamble to this proposed rule, found at 50 Fed. Reg. 24366, 24381-24383 (June 10, 1985), did not discuss the newborn bed exclusion, either in regard to what was meant by newborn beds or in regard to the policy behind said exclusion.

The exclusion of newborn beds was included in the final rule, effective October 1, 1985. See 50 Fed. Reg. 35646, 35690 (September 3, 1985). The final rule, quoted above, added custodial care beds to the categories of beds excluded from the IME calculation. In the proposed rule, one commenter requested a more precise definition of the term "available bed day". The comment and response were as follows:

> Comment: One commenter requested a more precise definition of the term "available bed days.
>
> Response: For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable) maintained for lodging inpatients. Beds used for purposes other than inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

50 Fed. Reg. 35646, 35683 (Sept. 3, 1985).

Until 1988, there was nothing in the Provider Reimbursement Manual, Part I (HCFA Pub.15-1) which indicated that the term "newborn beds" in 42 C.F.R. § 412.118(b) should be

interpreted to exclude newborn intensive care beds in the IME calculation. In 1988, HCFA imposed a qualification on the regulation, by defining beds as follows:

> A bed is defined [for purposes of the IME calculation] as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3.G. This manual provision was effective August 25, 1988.

PROVIDERS' CONTENTIONS:

The Providers argue that the plain language of the IME regulation requires that all beds assigned to newborns, including beds assigned to newborns in the intensive care unit, be excluded from the IME calculation. The Providers also assert that to include intensive care unit beds in the IME count would be arbitrary and capricious.

The Providers point out that the regulation at issue in this appeal, 42 C.F.R. § 412.105(b), states that "the number of available bed days during the cost reporting period, not including beds assigned to newborns . . . ." (emphasis added). There was no information in the preambles to either the proposed or final regulation that gave any interpretation or explanation to the term "beds assigned to newborns." The Providers assert that this plainly means recently born individuals or neonates. It is also clear that the Providers' neonatal intensive care unit cared for newborns and as such, these are beds assigned to newborns under the regulation.

The Providers maintain that HCFA must be bound by its own regulation and that HCFA Pub. 15-1 § 2405.3.G which requires that some of the beds assigned to newborns be included in the IME calculation is contrary to the regulation. This fact was noted by the Board in its decision in Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, PRRB Case No. 95-D15, January 4, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,021, rev'd HCFA Administrator, February 21, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,140 ("Humana"). The Board stated that the IME regulation:

> clearly instructs the intermediary to exclude all beds assigned to newborns whether the newborns are located in a routine or an intensive care unit. Because the applicable regulation includes specific instructions relating directly to the computation of the IME cost adjustment factor, . . . the Intermediary's retroactive application of a revised manual guideline effective August 1988 . .

> . [was] an improper and arbitrary action which totally ignores the governing regulation.

Id., ¶ 43021, at 43151 (emphasis added).

The Providers indicate that the HCFA decision to include the neonatal intensive care beds in the IME count is arbitrary and capricious. The Providers note that the HCFA Administrator in Humana stated that:

> this regulation does not 'clearly . . . exclude all beds assigned to newborns whether the newborns beds are located in a routine or an intensive care unit.' The reference to 'newborns' in the regulation can reasonably be interpreted to exclude only newborn bassinets receiving routine care. Further, the language of the regulation permits an interpretation that neonatal special care beds are properly counted as special care unit beds.

Id. ¶ 43,140, at 43,661.

The HCFA Administrator relied on the following in making this decision:

1. PRM-I § 2510.5A, issued to establish bed size categories for purposes of applying the cost limits under section 223 if the Social Security Amendments of 1972, excludes newborn beds but specifically includes beds in intensive care units and other special care inpatient hospital units.

2. PRM-I § 2202.7.A, issued in 1977, describes the composition of a special care unit, and includes intensive care units in that definition. Moreover, this section of the PRM specifically notes that bed days in neonatal units which qualify as special care units are to be considered intensive care days rather than nursery days.

3. PRM-I § 2405.3.G, issued in 1988, specifically excludes beds 'assigned to newborns which are not in intensive care areas . . .' from the count of available beds, noting that '[n]ewborn bassinets are not counted.' Thus, this section incorporates into a single section existing policy setting forth the method for counting beds which had previously been expressed in several sections.

4. [T]he preamble to the 1985 final rules discussed only one comment regarding available beds, specifying that "'available beds' are generally defined as adult beds or pediatric beds (exclusive of newborn bassinets . .)".

Id. ¶ 43,140, at 43,662-3.

The Providers indicate that this decision relied upon two manual provisions, HCFA Pub. 15-1 §§ 2510.5.A and 2202.7.A, which are no longer effective and/or not applicable to IME calculations. The Providers further contend that the HCFA Administrator decision has impermissibly applied HCFA Pub. 15-1 § 2405.3.G which is inconsistent with the regulation and not lawfully promulgated and the long standing policy is not supported by any evidence.

The Providers point out that on August 25, 1988 HCFA imposed a qualification on the regulation at § 412.118(b). A manual provision was adopted at HCFA Pub. 15-1 § 2405.3.G to specifically include neonatal intensive care unit beds in the IME calculation. The Providers contend that HCFA cannot, however, modify a clear regulatory requirement by implementing a manual provision which restricts the regulatory language. The Providers argue that if HCFA's manual provision was merely an interpretation of the regulatory language, then it might be permissible. However, the amendment of the term "newborn beds" clearly has a substantive effect. The Providers contend that such a change would be subject to Administrative Procedure Act requirements of notice and opportunity for public comment before such a change can be made.
5 U.S.C. § 553(b) and (c); Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232, 1239 (1995) ("APA rulemaking would be required if [an interpretive rule] . . adopted a new position inconsistent with any of the Secretary's existing regulations."). Therefore, the adoption of this manual provision, cannot be applied to the Providers.

It is the Providers' position that HCFA Pub. 15-1 § 2405.3.G would effect a substantive change in, and effectively add a new requirement to, the IME adjustment calculation as outlined in the regulation. The Providers contend that while the regulation would mandate the exclusion of all newborn beds in the IME bed count, § 2405.3.G of the manual would mandate the inclusion of some, but not all, "beds assigned to newborns." The Providers assert that this manual provision has clearly added a new requirement to the regulation at § 412.118(b) that is directly contrary to that regulation, and could not be valid until it was promulgated as a proposed rule with prior publication and opportunity for public comment.[2]

The Providers note that the Administrator claims in his decision that the inclusion of newborn intensive care beds in the IME calculation is pursuant to a longstanding policy. However, the Administrator fails to provide any support for this position. As noted before, there was no discussion in the proposed or final preambles to the original regulation. In Humana, supra, no authority is given for the proposition that "newborn bassinets" are anything other than "beds assigned to newborns," and none of the HCFA Pub. 15-1 section relied on even uses the term bassinet. In fact, HCFA Pub. 15-1 § 2200.2 defines a "bed" as "an adult or pediatric bed (exclusive of a newborn bed whether in the nursery . . or in the premature nursery [or Neonatal intensive care unit]." In any event, the Providers argue that the 1985 regulation

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[2] In 1994, HCFA amended 42 C.F.R. § 412.118(b) through notice-and-comment rule making to include newborns in an intensive care unit in the IME bed count. See 59 Fed. Reg. 45329, 45398 (Sept. 1, 1994).

clearly changed any prior existing longstanding policy. Since HCFA had previously drafted policy prior to 1985 to exclude neonatal intensive care units it clearly could have done so in the new 1985 regulation and therefore must have meant to change that policy, if it existed.

In summary, the Providers request the Board follow the regulation which requires exclusion of all newborn beds, including neonatal intensive care beds, from IME calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that nursery beds which meet the criteria for a special care unit should be included in the bed count used in the indirect medical education formula.

The Intermediary refers to the regulations in effect at the start of the 1988 year end which rule indirect medical education. 42 C.F.R. § 412.118(b) defines beds as follows:

> [d]etermination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.118(b).

The Intermediary points out that this definition was originally published in the September 3, 1985 Federal Register. One commentor to the proposed rule requested a more precise definition of the term "available bed days". The response was as follows:

> Response: For purposes of the prospective payment system, "available beds" are generally defined as adult or pediatric beds (exclusive of newborn bassinets, beds in excluded units, and custodial beds that are clearly identifiable maintained for lodging inpatients. Beds used for other inpatient lodging, beds certified as long-term, and temporary beds are not counted. If some of the hospital's wings or rooms on a floor are temporarily unoccupied, the beds in these areas are counted if they can be immediately opened and occupied.

50 Fed. Reg. 35646, 35683 (September 3, 1985).

The Intermediary contends that the policy consideration for including NICU beds in the IME calculation is that interns and residents receive extensive training on the treatment of infants who need special care (and will usually stay in the hospital for a considerable length of time) versus infants who are in the nursery (and usually will go home shortly after birth).

The Intermediary notes that this was further clarified in the Federal Register dated September 1, 1994, which reiterated this policy, in part as follows:

> As explained in the proposed rule and repeated above, we are only clarifying our long-standing policy position regarding neonatal intensive care beds and are not making a change in policy. We note that the United States Court of Appeals for the Eighth Circuit recently upheld this longstanding policy Sioux Valley Hospital v. Shalala, No. 933741 SD (8th Cir. July 20, 1994).

59 Fed. Reg. 45329, 45374 (September 1, 1994).

The Intermediary refers to the HCFA Administrator's decision in Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, Medicare & Medicaid Guide (CCH)
¶ 40,747, August 26, 1992, rev'd HCFA Administrator, October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044 ("Sioux Valley"), in which the Administrator reversed the Board and upheld the Intermediary on the position that NICU beds are to be included in the IME calculation. The Administrator found that the Program instructions were consistent with the regulations in including these beds based on a long-standing policy of the Medicare Program of including all ICU beds in the bed count. The Intermediary points out that the Administrator also found that HCFA's method of counting beds was not modified by regulation 42 C.F.R. § 412.118(b). The Administrator stated:

> [t]he reference to "newborns" in the regulation can reasonably be interpreted to exclude only newborn bassinets receiving routine care. Further, the language of the regulation permits an interpretation that neonatal intensive care beds are properly counted as ICU beds. Accordingly, the Intermediary's adjustment in this case, which included the Provider's ICU beds in the determination of the resident-to bed ratio of the IME cost calculation, was proper.

HCFA Administrator's Decision in Sioux Valley.

In the instant case, the Intermediary believes that the same interpretation of what constitutes newborn days should be made. The NICU beds in question are not considered bassinets and refer to special care unit type of care at the Providers. As a result, these beds should be considered beds to be included in the Providers' IME calculation.

The Intermediary also notes that the HCFA Administrator's interpretation has also been upheld in Hahnemann University Hospital v. Shalala, C.A. No. 94-2457(JHG), (D.D.C. April 17, 1996).[3] This decision stated that the Administrator's interpretation of the regulation to

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[3] Intermediary Exhibit 1-6.

allow the inclusion of NICU beds in the bed count used to calculate the IME adjustment was reasonable and based on long standing agency policy and practice.

The Intermediary notes that the exclusion of newborn days had been applied by the Medicare Program as early as 1976 through the inpatient cost limits (Section 223 of the Social Security Amendments of 1972).[4] Also, various Program instructions from 1977 onward (i.e., HCFA Pub. 15-1, § 2202.7A on Special Care Units) included NICU days as special care unit days rather than nursery days. The Intermediary asserts that the program instructions found in HCFA Pub. 15-1, Section 2405.3.G incorporated into a single section existing policy setting forth the method of counting beds which had previously been expressed in several sections.[5]

The Intermediary notes that Transmittal No. 345[6] to HCFA Pub. 15-1, was issued in August 1988, with an effective date of August 25, 1988. This transmittal revised various parts of Section 2405.3, Adjustments for the Indirect Cost of Medical Education. The Intermediary believes that this section was revised to clarify the definition of beds to be used for IME. This clarification further supports the Intermediary's treatment of including NICU beds in the IME calculation.

The Intermediary contends that the California Department of Health includes NICU beds in a provider's license because these beds are regarded as another type of pediatric bed, i.e., Special Pediatric Beds.[7] The Intermediary believes the reason the Department includes these as licensed beds is because the neonatal patients generally have long-term stays in the hospital compared to nursery patients. In a monthly printout from the Department called "Summary of Report for Hospitals", both Neonatal Intensive Care Unit and Special Care Nursing Unit beds are listed as Special Pediatric beds under the licensed beds for hospitals. As indicated in the Department's Certificate of Need standards, these beds are intended for the care of all seriously ill or risk newborn infants who require complex services.[8]

To distinguish neonatal beds from newborn bassinets, the Department of Public Health defined these bassinets as unlicensed bassinets operated as part of the obstetrical services of a hospital.

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4 Intermediary Position Paper at 4.

5 Id.

6 Intermediary Exhibit 5.

7 Intermediary Position Paper at 5.

8 Id.

The Intermediary's contends that the above regulations and Program instructions show that NICU patients were merely another type of intensive care patient required to be included in the bed count. The Intermediary asserts that these patients were regarded by the Medicare Program as not newborn but as another type of intensive care unit patient. Therefore, it was appropriate for the Intermediary to include these beds in the bed count for the IME calculation.

The Intermediary maintains that its calculation of the IME payment, by including NICU beds in the bed count, is based on the Program regulations and instructions and has been upheld by the Administrator and the Courts. The Intermediary requests that the Board uphold the audit adjustments.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law:

42 U.S.C. § 1395ww(d)(5)(B)	-	Payment to Hospitals for Inpatient Hospital Services - Indirect Medical Education Costs
5 U.S.C. § 553(b)	-	Administrative Procedure Act

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

§ 405.477(d)(2) [1984]	-	Payments to Hospitals Under the Prospective Payment System: Additional Payments: Indirect Medical Education Costs
§ 405.1835-.1841	-	Board Jurisdiction
§ 412.118 (Redesignated 412.105)	-	Determination of Indirect Medical Education Costs

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

§ 2200.2	-	Availability of Apportionment Methods for Cost Reporting Periods Starting After December 31, 1971, But Before July 1, 1979

§ 2202.7A	-	Special Care Units/Intensive Care Type Units
§ 2405.3 et seq.	-	Adjustment for the Indirect Cost of Medical Education
§ 2510.5.A	-	Determining Hospital Bed Size: Bed Size Determination

4. Cases:

Grant Medical Center v. Community Mutual Insurance Company/Blue Cross and Blue Shield Association/Community Mutual Insurance Company, PRRB Dec. No. 97-D67, June 18, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,453, declined rev. HCFA Administrator, July 30, 1997.

Hahnemann University Hospital v. Shalala, C.A. No. 94-2457(JHG), (D.D.C. April 17, 1996).

Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5, 1997) (per curiam)

Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, PRRB Case No. 95-D15, January 4, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,021, rev'd HCFA Administrator, February 21, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,140.

Kern Medical Center v. Blue Cross & Blue Shield Association./Blue Cross of California, PRRB Dec. No. 95-D42, June 13, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,467.

Little Company of Mary Hospital and Health Care Centers v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, October 21, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part HCFA Administrator, December 22, 1997, Medicare & Medicaid Guide (CCH) ¶ 46,053.

Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232 (1995).

Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994).

Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D53, August 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,747, August 26, 1992, rev'd HCFA Administrator, October 26, 1992, Medicare & Medicaid Guide (CCH) ¶ 41,044.

5. Other:

HCFA Transmittal No. 345 (August, 1988) - Adjustment for the Indirect Cost of Medical Education

59 Fed. Reg. 45329 (September 1, 1994).

56 Fed. Reg. 43241 (August 30, 1991).

50 Fed. Reg. 12740, 12759 (March 29, 1985).

50 Fed. Reg. 24366 (June 10, 1985).

50 Fed. Reg. 35646 (September 3, 1985).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties contentions, and evidence presented, finds and concludes that the Intermediary's inclusion of NICU beds in the IME calculation was proper.

The Board notes that the issue in this case has been brought before it many times in the past. The Board finds that its original position opposing the inclusion of NICU beds in the IME adjustment calculation was predicated on the Board's literal interpretation of 42 C.F.R. § 412.118(b). See Kern Medical Center v. Blue Cross & Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D42, June 13, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,467. This subsection, states in part:

> [d]etermination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.118(b) (emphasis added).

The Board further notes that the Board majority modified the above position for cases with fiscal years beginning after the manual revision to HCFA Pub. 15-1, § 2405.3.G on August

25, 1988. See Grant Medical Center v. Community Mutual Insurance Company/Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Community Mutual Insurance Company, PRRB Dec. No. 97-D67, June 18, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,453, declined rev. HCFA Administrator, July 30, 1997. HCFA Pub. 15-1, § 2405.3.G defines beds as follows:

> [a] bed is defined [for purposes of the IME calculation] as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units.

HCFA Pub. 15-1 § 2405.3.G (emphasis added).

The Board takes judicial notice of two U.S. Circuit Court of Appeals decisions on the same issue as presented in the instant case. See Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994) and Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5, 1997) (per curiam). These two Circuit Court decisions put forth an interpretation of the issue in this case different from earlier Board decisions and different from the Board majority's most recent decision in Little Company of Mary Hospital and Health Care Centers v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, October 21, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Administrator, December 22, 1997, Medicare & Medicaid Guide (CCH) ¶ 46,053.

The Board finds the Circuit Courts' decisions persuasive, and therefore gives deference the Circuit Courts' decisions in their interpretation of the regulations regarding the inclusion of NICU beds in the IME calculation.

DECISION AND ORDER:

The Intermediary properly included NICU beds in the IME calculation. The Intermediary's action is affirmed.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman