PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D54

PROVIDER -
Daniel Freeman Marina Hospital
Marina Del Ray, California

Provider No. 05-0559

vs.

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

DATE OF HEARING-
December 10, 1999

Cost Reporting Period Ended -
June 30, 1994

CASE NO. 96-2623

INDEX

ISSUE:

Did the Intermediary properly include the Provider's inpatient Part B charges with outpatient Part B charges, thereby subjecting the inpatient Part B charges to the 5.8% outpatient cost reduction?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Daniel Freeman Marina Hospital ("Provider") is a 203-bed short-term non-profit hospital located in Marina Del Rey, California. On April 1, 1994, Blue Cross of California ("Intermediary"), issued a Notice of Program Reimbursement ("NPR") for the Provider's fiscal year ended ("FYE") June 30, 1994. Pursuant to audit adjustment 5, the Intermediary adjusted the Provider's Medicare Part B charges. The charges, as adjusted, include in Medicare Part B charges the charges for ancillary services furnished to Medicare inpatients which were covered under Medicare Part B, because Medicare Part A coverage was not available. Because the charges for inpatient Part B services were included with outpatient charges in the Provider's Medicare cost report, such charges were subject to a 5.8% outpatient cost reduction factor. Subjecting the inpatient Part B charges to the 5.8% outpatient cost reduction factor reduced the Provider's Medicare reimbursement by approximately $2,900. On September 25, 1996, the Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. '' 405.1835-.1841 and has met the jurisdictional requirements of those regulations.

During the cost reporting period under appeal, the Provider furnished certain ancillary services to hospital inpatients which were not covered under Medicare Part A, but which were covered under Medicare Part B. These ancillary services included services furnished to inpatients, who had (1) exhausted their allowed inpatient days under Part A during the current spell of illness, (2) were determined to be receiving a non-covered level of care; or (3) were otherwise not eligible for, or entitled to coverage under Part A. These services are referred to as inpatient Part B ancillary services. The Provider included its charges for the inpatient Part B ancillary services with all other outpatient charges on its FYE June 30, 1994 as-filed cost report, because there is no location on the cost report to include these charges as inpatient Part B charges separate from the outpatient charges.

Because the Provider's charges for inpatient Part B ancillary services were included with its outpatient charges on its Medicare cost report, the Provider's Medicare reimbursement for inpatient Part B ancillary services was reduced by the 5.8% outpatient cost reduction factor enacted by Congress pursuant to ' 4151(b)(1) of the Omnibus Budget Reconciliation Act of 1990 ("OBRA90"), 42 U.S.C. ' 1395x(v)(1)(S)(ii).

Application of the 5.8% cost reduction factor occurs as follows in the Provider's Medicare cost report:

1. The cost to charge ratio for outpatient services for each ancillary cost center is determined on Worksheet C, Part 11. When computing the cost to charge ratio for hospital outpatient services, operating costs are reduced by 5.8%. Capital costs are reduced by a separate factor, which is not at issue here. This occurs on Worksheet C, Part 11.

2. To determine Medicare reimbursement for hospital outpatient services, the outpatient cost-to-charge ratio determined on Worksheet C, Part 11 is multiplied by the Provider's Medicare charges for hospital outpatient services, separately for each ancillary cost center. See Worksheet D, Part V.

3. The outpatient charges to which the outpatient cost-to-charge ratio is applied are included in Worksheet D, Part V, Column 5, which is entitled "All Other Part B."

   Included in Column 5 are charges for inpatient Part B ancillary services. Because these charges were included with outpatient charges in the "All other Part B"charge column, they were subjected to the 5.8% outpatient cost reduction factor in determining the Provider's reimbursement for the inpatient Part B ancillary services.

The Provider was represented by Lloyd A. Bookman, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the application of the outpatient cost reduction factor to inpatient Part B ancillary services is inconsistent with the plain language of Section 4151(b)(1) of OBRA 90, 42 U.S.C. ' 1395x(v)(1)(S)(ii), the statute which included the outpatient cost reduction factor. That statute provides that:

> [t]he Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital related costs of such services) otherwise determined pursuant to Section 1833(a)(2)(B)(i)(1) by 5.8% for payments attributable to portions of cost reporting periods occurring during fiscal years 1991, 1992, 1993, 1994, or 1995.

Id.

The Provider contends that the statute directs that the 5.8% reduction should be applied to the reasonable cost of "outpatient hospital services." The Provider contends that services covered under Medicare Part B which are furnished to hospital inpatients are not outpatient hospital services.

The Provider points to the definitions of inpatient and outpatient hospital services in the Medicare Intermediary Manual ("HCFA Pub. 13") to support its position. A hospital inpatient is defined in the MIM as a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. See HCFA Pub. 13-3 ' 3101. A hospital outpatient is defined as a person who has not been admitted by the hospital as an inpatient but who is registered on the hospital records as an outpatient and receives services from the hospital. HCFA Pub. 13-3 ' 3112.1. The Provider contends that it is uncontroverted that the patients who received the inpatient Part B ancillary services were hospital inpatients. These patients had been admitted to the hospital for bed occupancy in order to receive inpatient hospital services. These patients were not registered on the hospital's records as outpatients.

According to the Provider, because the patients are hospital inpatients and not hospital outpatients, these Part B ancillary services are not hospital outpatient services. This outpatient cost reduction factor is to be applied under ' 4151(b)(1) of OBRA 90, 42 U.S.C. ' 1395x(v)(1)(S)(ii), only to hospital outpatient services, and the outpatient cost reduction factor may not be applied to inpatient Part B ancillary services.

The Provider further notes that the courts have repeatedly held that the most important consideration in determining the meaning of the statute is the plain language of the statute. See Ardestani v. INS, 502 U.S. 129, 112 S.Ct. 515 (1991); Estate of Cowart v. Niklos Drilling Co., 112 S.Ct. 2589, 2592 (1992). The Provider asserts that the Intermediary has demonstrated no basis for the Board to ignore the plain language of the statute.

The Provider points out that treating inpatient Part B ancillary services differently from hospital outpatient services would be consistent with the approach taken throughout the Medicare program. Inpatient services under Part A, inpatient Part B ancillary services, and hospital outpatient services are treated differently under the Medicare program for various reasons. During the fiscal period at issue, inpatient Part A services were reimbursed under the Medicare prospective payment system pursuant to the 'DRG" methodology, and inpatient Part B ancillary services were reimbursed on a reasonable cost basis. Many outpatient services were not reimbursed on a reasonable cost basis. For example, outpatient hospital clinical laboratory services were reimbursed on the basis of a fee schedule. Outpatient radiology and other outpatient diagnostic services were reimbursed on a blend of costs and a fee schedule.

Similarly, inpatient Part A services, inpatient Part B ancillary services, and outpatient services are all treated differently in the Medicare claims processing system. Inpatient Part A services are identified as Type 1 services in Medicare claims, inpatient Part B ancillary services are identified as Type 2 services, and outpatient services are identified as Type 3 services.

The Provider also contends that the statutory provisions pertaining to reimbursement for outpatient clinical laboratory services and outpatient radiology services support its position that inpatient Part B ancillary services are not hospital outpatient services for purposes of Medicare reimbursement. The Secretary of Health and Human Services ("Secretary") was directed to establish fee schedules for clinical diagnostic laboratory tests pursuant to 42 U.S.C. ' 13951(h). It states that the "fee schedules are to be provided for clinical laboratory tests . . . for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider." Id. The Secretary has implemented this provision by applying the clinical laboratory fee schedules to only laboratory tests furnished to hospital outpatients, and not to laboratory tests finished to hospital inpatients, even where such tests are covered under Medicare Part B.

Further, pursuant to 42 U.S.C. ' 13951(a)(2)(E), "outpatient hospital radiology services" are excluded from reimbursement on a reasonable cost basis and are reimbursed pursuant to a blend of costs and a fee schedule amount. The Medicare program has continued to reimburse hospital radiology services furnished to inpatients who have Part B only coverage on a reasonable cost basis. It is clear that the program has recognized that outpatient hospital radiology services and inpatient Part B radiology services are different and are not treated in the same fashion for Medicare reimbursement purposes. Thus, the Medicare program has recognized that the term outpatient hospital services does not include within it inpatient Part B services.

Finally, the Provider argues that the statutory provisions implementing an outpatient prospective payment system demonstrate that Congress understands hospital outpatient services and inpatient Part B ancillary services to mean different things. Pursuant to 42 U.S.C. ' 13951(t)(1)(A) the new outpatient prospective payment system is to apply to "covered OPD services." The term "covered OPD services" is defined to include (1) hospital outpatient services designated by the Secretary, and (2) inpatient hospital services designated by the Secretary which are covered under Part B and furnished to a hospital inpatient who (i) is entitled to benefits under Part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (ii) is not so entitled. Id. The explicit language used by Congress to subject inpatient Part B ancillary services to the new outpatient prospective payment methodology indicates that the term "hospital outpatient services" does not include inpatient Part B ancillary services. There would have been no need for Congress to separately identify inpatient Part B ancillary services in the statute if they were included within the meaning of the term "outpatient hospital services." The statute reflects that Congress knew how to clearly and expressly identify outpatient Part B ancillary services when it so intended.

Finally, the Provider contends that the Intermediary's reliance on the cost report instructions is erroneous. If the cost report instructions are interpreted, as the Intermediary contends, to require that inpatient Part B ancillary services be subjected to the outpatient cost reduction factor, then the cost report instructions are invalid as being inconsistent with the Medicare statute. It is clear that a cost report instruction which is inconsistent with a provision of the Medicare Act is invalid. See Pacific Coast Enterprises v. Harris, 633

F.2d 123 (9th Cir. 1980).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Medicare cost report instructions, specifically HCFA Pub. 15-2 ' 2814.5 requires that inpatient Part B ancillary charges be included with outpatient charges in the Medicare cost report for purposes of cost apportionment. It states that:

> [t]his worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B.

HCFA Pub. 15-2 ' 2814.5.

The outpatient cost reduction factor, or sequestration adjustment, is made after determining the amount of total Medicare payment due to the provider for covered services furnished to eligible beneficiaries during the cost reporting year. In preparing the cost report, a provider would apply the appropriate reduction percentage to reduce the total net costs reimbursable to the provider as part of the process of arriving at the balance due the provider/program on Worksheet E, Part B. Since the reduction rate in question affects Part B only, the Intermediary is required to apply the
effective rate to Worksheet E, Part B of the Provider's cost report. The Intermediary contends that it was required to follow the cost report instructions.

The Intermediary also contends that the Provider's position would require the Medicare program to adopt a three tier reimbursement methodology. The Intermediary contends that the Medicare program only contemplates a two tier reimbursement methodology, one tier for hospital outpatient services and a second tier for all services furnished under Medicare Part B.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 1395l(a)(2)(E)	-	Amount of Payment
' 1395l(h)	-	Clinical Diagnostic Laboratory Services
' 1395l(t)(1) et seq.	-	PPS for Hospital Outpatient Services
' 1395x(v)(1) et seq.	-	Reasonable Cost

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.124	-	Reduction to Hospital Outpatient Operating Costs

3. Program Instructions- Provider Reimbursement Manual (HCFA Pub. 15-2):

' 2814.5	-	Part V - Apportionment of Medical and Other Health Services Costs

4. Medical Intermediary Manual (HCFA-Pub 13-3):

' 3101	-	Cover Inpatient Hospital Services
' 3112.1	-	Outpatient Defined

5. Cases:

Ardestani v. INS, 502 U.S. 129 (1991)

Estate of Cowart v. Niklos Drilling Co., 112 S.Ct. 2589 (1992)

Pacific Coast Enterprises v. Harris, 633 F.2d 123 (9th Cir. 1980).

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence submitted, finds and concludes that based on the plain language of the applicable statute and the Secretary=s own regulation, the outpatient reduction factor at issue in this case may not be applied to inpatient Part B services. The Board notes that the applicable statute, 42 U.S.C. ' 1395x(v)(1)(S)(ii)(II) provides as follows.

> The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(II) [42 U.S.C. '1395l(a)(2)(B)(II)] of this title to be 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and, during fiscal years 2000 before January l, 2000.

Id.

Similarly, the Secretary's regulation at 42 C.F.R. ' 413.124 indicates that the 5.8 percent reduction only applies to outpatient services:

> [T]he reasonable costs of outpatient hospital services (other than capital related costs of such services) are reduced by 5.8 percent for services rendered during portions of cost reporting periods occurring on or after October 1, 1990 and before October 1, 1998.

Id.

The Board finds that the above statute and regulation specifically refer to the reduction of outpatient services. The Board notes that there was nothing in evidence of notice given by the Secretary of her intent to reduce inpatient Part B costs.

The Board further notes that the Intermediary did not challenge the Provider's claim that the inpatient Part B services at issue were in fact furnished to hospital inpatients, not hospital outpatients, and therefore, constitute hospital inpatient services, not hospital outpatient services. Accordingly, as noted above, the Board concludes that based on the plain language of the statute and regulation, the outpatient cost reduction factor may not be applied to inpatient Part B services.

The Board also finds that its conclusion is supported by the language in the statute instructing the Secretary to adopt a prospective payment system for hospital outpatient services. The Board believes that Congress was aware that hospital outpatient services and inpatient Part B services were different by the definition of covered outpatient department services. Covered outpatient department services include: (1) hospital outpatient services designated by the Secretary; and (2) inpatient hospital services designated by the Secretary that are covered under Part B and furnished to a hospital inpatient . . . . See 42 U.S.C ' 1395l(t)(1) et seq. By separately designating hospital outpatient services and inpatient hospital services covered under Part B, Congress indicated clearly that hospital outpatient services and inpatient hospital services covered under Part B are different.

The Board notes that the Intermediary points out that it used the existing cost report forms and instructions and that these forms and instructions apply the 5.8 percent reduction factor to inpatient Part B services in addition to outpatient services. The Board believes that to the extent that cost report forms and instructions require the resultant reduction to inpatient Part B services, the forms and instructions are contrary to statute and regulation at 42 U.S.C. ' 1395x(v)(1)(S)(ii)(II) and 42 C.F.R. ' 413.124 respectively, and are therefore invalid. The Board believes that if the forms and instructions are wrong and contrary to the statute and regulation, HCFA should correct them.

The Board also rejects the Intermediary's contention that the Provider is impermissibly creating a three tier approach to Medicare reimbursement. The Board agrees with the Provider that the Medicare program has encompassed a three tier approach, establishing separate reimbursement methodologies for inpatient Part A services (DRG-based reimbursement), inpatient Part B ancillary services (reasonable cost reimbursement), and hospital outpatient services (a mix of reasonable cost reimbursement, fee schedule reimbursement, and a blend of fee schedule and reasonable cost reimbursement). Thus, the Board finds that the Provider's approach of treating inpatient Part B ancillary services differently from hospital outpatient services is consistent with the general approach used by the Medicare program.

DECISION AND ORDER:

The Intermediary improperly applied the outpatient cost reduction factor to the Provider's inpatient Part B services. The Intermediary is ordered to compute an adjustment to the Provider's Medicare reimbursement to remove the application of the outpatient Part B reduction factor from the Provider's inpatient Part B costs.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE RECORD

Irvin W. Kues
Chairman