PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2003-D38

PROVIDER –
Starke Memorial Hospital
Knox, Indiana

Provider No. 15-0102

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/AdminaStar Federal

DATE OF HEARING -
March 25, 2003

Cost Reporting Period Ended -
March 31, 1998

CASE NO. 01-1637

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ISSUE:

Was the Intermediary's adjustment to limit reimbursement to the lower of cost or charges for the Provider's distinct part psychiatric unit proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Under §1814(b) of the Social Security Act, as amended, 42 U.S.C. § 1395f, a provider of services is reimbursed for those services rendered to Medicare beneficiaries in an amount which is the lesser of the reasonable cost of such services or the customary charges (LCC) with respect to such services. The Secretary has promulgated regulations at 42 C.F.R. § 413.13 to implement this statutory limitation on reimbursement. This case concerns the application of LCC to a distinct part psychiatric unit.

On April 1, 1997, Starke Memorial Hospital (Provider) opened a distinct part psychiatric unit which was certified by the Health Care Financing Administration (HCFA)[1] as being exempt from the Prospective Payment System and issued a separate provider number, 15-S102. The unit was operated for a period of six months and was closed in October, 1997. The cost of the unit for this period was $866,304 and the charges were $550,304. The Intermediary applied LCC solely to the unit, which resulted in a decrease of approximately $316,000 in Medicare reimbursement. The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider is represented by Joanne B. Erde, Esquire, of Broad and Cassel. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that: (1) the Intermediary erred by not applying LCC to the Provider's aggregate Part A costs and charges and, (2) the Provider's psychiatric unit is not a provider of services to which LCC may be separately applied. The Provider interprets the Medicare rules and regulations to mandate that LCC be applied to each provider of service costs and charges in the aggregate. The only disaggregation of the application of LCC within a provider of services is between Medicare Part A and Part B services. Section 1814(b) of the Social Security Act establishes the LCC, which limits payments to "providers of service" to the lower of the reasonable cost or the customary charge for its services. The term "provider of services" is defined by Section 1861(u) of the Social Security Act to mean a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or a hospice program. These are the only entities that the statute includes as a "provider of services." As such, these are the only providers of services to which LCC may be applied. Thus, the Provider argues that the statutory language clearly states that the LCC may only be applied to a provider of services. Similarly, the regulation promulgated to implement this

[1] Now known as Centers For Medicare and Medicaid Services (CMS).

statutory mandate, 42 C.F.R. § 413.13, requires LCC to be applied to each "provider of services."

In recognition of this clear language, the Provider observes that the Administrator of HCFA[2] opined that "[t]hroughout the regulation, the LCC limitation is applied in reference to a single provider. Costs and charges are respectively aggregated within each provider to determine the applicability of this limitation." St. Luke's Hospital v. Aetna Casualty Company, HCFA Admin. Dec. 84-D-15, Medicare & Medicaid Guide (CCH) ¶ 33,926 March 7, 1984, (St. Luke's). The Administrator in another decision also concluded that since the hospital and its skilled nursing facility were each identified as separate providers under Section 1861(u) of the Social Security Act, LCC had to be applied separately to each provider of services. HCFA Administrator Dec. 78-D9, Medicare and Medicaid Guide (CCH) ¶ 29,032 May 5, 1978. Furthermore, in February of 1979, the Administrator made the same determination based upon Section 1861(u) of the Social Security Act. HCFA Administrator Dec. 78-D85, Medicare and Medicaid Guide (CCH) ¶ 29,638 (Feb. 15, 1979). Thus, Provider argues that the Secretary has repeatedly and consistently followed the clear language of the Medicare statutes and regulations and applied LCC to the aggregate costs of each separate provider of services. The clear and unambiguous language of a statute governs the definition of a "a provider of services." The Provider refers us to Barnhart v. Sigmon Coal Company, Inc., et at, 122 S. Ct. 941, 950; 934 U.S. 438 (2202), relying on Chevron U.S.A., Inc. v. N.R.DG., 467 U.S. 837, 842-3 (1984), in which the Supreme Court ruled that if the "statutory language is unambiguous and the statutory scheme is coherent and consistent, the inquiry ends." Id.

The Intermediary contends that HCFA, through its regulations and instructions, intended that LCC be applied separately to all provider components. It relies on 42 C.F.R. § 412.22, Excluded hospitals and hospital units which states:

> (b) Cost reimbursement. Except for those Hospitals specified in paragraph (c) of this section, all included hospitals (and excluded hospital units as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in Part 413 of this chapter and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this chapter.
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> (Emphasis added)

The regulation controlling LCC is 42 C.F.R. § 413.13. The Intermediary acknowledges that the above reference does not specifically make mention of an excluded unit, but argues that it is clearly noted in 42 C.F.R. § 412.22 that 42 C.F.R. § 413.13 applies to excluded units. The Intermediary argues further that instructions in the Provider Reimbursement Manual, HCFA Pub. 15-1 § 2336, which address multiple-facility hospitals support its position and that this

[2] Now called Centers For Medicare and Medicaid Services

manual section is clearly consistent with § 1814(b) of the Social Security Act. The Court in Lafayette Home Hospital Inc. v. Califano, U.S. District Court, Northern District of Indiana, Civil No. L78-25, August 17,1979 (Lafayette), found that the intent of the LCC statute is to prevent a provider from receiving from Medicare amounts greater than the provider would charge for identical services to patients not covered by Medicare. Psychiatric and swing bed services are distinct types of services, recognized by the issuance of two separate provider numbers: 15-S102 for the psychiatric unit and 15-U102 for the swing bed unit.

The Provider characterizes the Intermediary's reliance on 42 C.F.R. § 412.22 as a "bootstrap" argument, not justified by its own language and inconsistent with clear and unambiguous statutory and regulatory language discussed above.

In response to the Intermediary's reliance on manual provisions, the Provider asserts that HCFA Pub. 15-1 § 2336 does not apply at all to the instant situation, and that the Intermediary's application of HCFA Pub. 15-1 § 2612, if correct, would cause that provision to be invalid as inconsistent with statute and regulation.[3]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence, finds and concludes that the Intermediary properly applied LCC to the Provider's distinct part psychiatric unit.

The Board observes that the Provider's position is founded on the premise that the Medicare statute regarding LCC permits it to be applied only to "providers" as the term is defined in § 1861(u) of the Social Security Act. The Provider then argues that all components of what makes up a provider must be aggregated before applying the LCC provisions. The Board does not agree with the Provider's interpretation of the statute. The statute does make reference to "amounts paid to providers." However, this does not necessarily require the application of LCC to a provider as a whole. Throughout the Medicare payment process, there are numerous special reimbursement treatments of various components, e.g., special care units, ancillary services, and distinct part units. Payment for each of these units is calculated on an independent and different basis. However, the Provider is the only entity to which reimbursement is made.

The Board finds that since the statute does not limit the application of LCC, the Board must next consider the Medicare regulations and their impact on LCC. These regulations have the force of law and constitute the official interpretation of Centers for Medicare and Medicaid Services. The regulations which apply to the Board[4] and case law[5] require the Board to give

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[3] Page 3 of Provider's Supplemental Brief.

[4] See, 42 C.F.R § 415.1867.

[5] See, e.g., Christensen v. Harris County, 529 U.S. 576 (2000).

effect to the Agency's regulations. Within this context the Board finds the Intermediary's analysis of regulatory support persuasive. Specifically, the regulation at 42 C.F.R. § 412.22(b) states that " . . . . [a]nd all excluded hospitals (and excluded hospital units, as described in § 412.23 through 412.29) are reimbursed under cost reimbursement rules set forth in Part 413 of this chapter . . . ." The Provider's psychiatric unit is a distinct part unit which meets the regulatory definition of an excluded hospital unit at 42 C.F.R. § 412.25. As such, Part 413 of the Medicare regulations, specifically 42 C.F.R. § 413.13, applies to this distinct part. In addition, the Board finds that since the above regulations clearly apply to the Provider's unit, there is no need to review the effect that the Provider Reimbursement Manual instructions would have on this situation.

Finally, the Board finds that the court cases cited by the Provider do not conflict with this decision. Importantly, the St. Luke's court decision established that there can be two separate providers within a hospital facility complex. The situation in the case now before the Board is quite different in that there is only one provider, but it has a distinct-part, PPS excluded unit.

Based on the above analyses, the Board concludes that the Provider's distinct-part psychiatric unit is subject to the LCC regulation at 42 C.F.R. § 413.13.

DECISION AND ORDER:

The Intermediary properly applied LCC to the Provider's distinct part psychiatric unit. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esq.

DATE: July 17, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman