PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D11

PROVIDERs –
Flagstaff Medical Center and
Northern Arizona Homecare-Flagstaff
Flagstaff, Arizona

Provider Nos.: 03-0023 and 03-7047

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC--CA/
BlueCross BlueShield of Arizona

DATE OF HEARING –
May 13, 2004

Cost Reporting Periods Ended -
December 31, 1994: June 30, 1995 and
June 30, 1997

CASE NOs.: 00-3166; 00-3167 and
00-3119 (respectively)

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ISSUE:

Whether the Intermediary's denial of a request for exception to the Home Health Agency (HHA) per visit cost limits was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider submitted requests for an exception to the cost limits to United Government Services (Intermediary) on March 20, 1997, December 5, 1997, and March 25, 1999 for fiscal years 1994, 1995 and 1997, respectively.[1] The basis of the exception requests was "under circumstances specified in 42 C.F.R. 413.30 section (f)(1), Atypical Services."

The Provider contends that it serves a large geographic area with low population density, and this caused Provider to incur an atypical amount of travel related expense and associated staff costs to meet the service needs of its patients.

For each of the years for which the exception request was made, the Intermediary reviewed the Provider's request and forwarded its recommendation (denial) to HCFA. The requests were subsequently reviewed and denied by CMS.

[1] The Provider has appealed three fiscal years ended in 12/31/94, 06/30/95, and 06/30/97.

CMS indicated that to qualify for an atypical service exception a provider must demonstrate that the patient care services furnished are atypical in nature and scope, that the services are furnished because of the special needs of the patients treated, and that the costs associated with these patient care services resulted in the agency's costs exceeding the per-visit limitations. In its denials, CMS noted that the Provider documented some transportation-related costs that were attributed to the geographic circumstances in which it operated. However, there was nothing in its application that demonstrated that the patient care services furnished were atypical and necessitated by the special needs of its patients.[2]

The Provider timely appealed CMS' determination under 42 C.F.R. §§405.1835-.1841. The Provider was represented by Gregory Kuzma, its Director of Financial Planning. The Intermediary was represented by James Grimes, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

It is the Intermediary's and CMS' position that items of service as described in regulation 42 C.F.R. §413.30(f)(1) relate to actual patient services or clinical treatment of patients in accordance with physician orders. In that regard, the Provider's claim for excessive travel expenses and associated staff costs would not amount to atypical services and would not justify an exception to the cost limit.[3] The provider argues that higher administrative costs were incurred because of the location of the Provider. However, the Intermediary points out that travel costs are not considered an atypical service under the regulations and therefore, should not qualify as an exception to the limits.[4]

The Provider contends that it properly documented its excessive travel costs, the number of visits by zip code and type of service, as well as the staffing costs related to these visits in the Provider's outlying service area.[5] The needs of these patients are self-evident in that they require home care services as prescribed by their physician, yet live in isolated rural areas that cause the provider to incur significant costs in reaching the patient.

The Provider also argues that the travel costs incurred are patient care related in accordance with CMS Pub. 15-1 §2102.2, which states:

> [t]hese include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted in the

[2] See Provider's position paper at P-7, page 2.
[3] See TR. 19-20.
[4] See Tr. 21.
[5] See Exhibit C contained within Provider Exhibit P-5 - Provider's request for exception to the HHA limits.

> field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs and others.

In support of its position, the Intermediary cites Campbell (Campbell) County Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Shield of Wyoming, PRRB Dec. No. 2000-D58, 08/19/1999.[6] In that case, the Board stated there were two bases for exceptions to the HHA cost limits under the regulations; atypical services and extraordinary circumstances. In Campbell, the Board agreed with HCFA's decision to deny the exception request based on the location of the Provider. The Board's rationale was that there is no specific regulatory relief based on geographic, demographic, or topographic factors. The Board further noted that the same cost limits apply to hospital-based as well as freestanding HHAs. Given the fact that the Campbell case is similar in circumstances to this instant case, the Intermediary sees no reason why the Board would change its decision and affirm the denial of the Provider's exception request to the HHA cost limits.

In response to the Campbell case, the Provider notes there are different limits applicable for rural and urban areas, with the rural limits set at a higher rate. Thus there is the appearance that there are cost differentials associated with operation in a rural area that legislation intended to address. The issue then is whether the provider is entitled to an exception for atypical costs when this differential is not adequate to cover cost incurred in providing care in a more sparsely populated rural area than what the limits provide for.

FINDINGS, CONCLUSIONS AND DISCUSSION:

After consideration of the Medicare law and guidelines, evidence presented and parties arguments, the Board finds and concludes as follows: The Board majority notes that in establishing limits on reimbursable costs, CMS classified providers by the type of provider and other factors, including type of services furnished, nature and mix of services, and geographical area where services are furnished. 42 C.F.R. §413.30(b)(i), (iv) and (ii), respectively.

The regulation at 42 C.F.R. §413.30(f)(1) provides an exception to the limits for atypical services. It requires the provider to show that the actual cost of "items or services" furnished exceeds the applicable limit because such items or services are atypical in nature and scope. The Board majority finds that "items and services" have to do with the actual clinical treatment of patients in accordance with orders given by the patient's physician or authorized healthcare provider. The Provider made no attempt to show that its "items or services" were "atypical in nature and scope." Unusual travel expenses resulting from the remote location of its patients would not qualify the Provider for an atypical services exception to its cost limits.

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[6] See Intermediary's position paper Exhibit I-3, Case No. 00-3167.

DECISION AND ORDER:

The Board Majority finds that the Intermediary's and CMS' determination to deny the Provider's exception request to the HHA cost limits for atypical services was proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire, Dissenting Opinion
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA, Dissenting Opinion
Anjali Mulchandani-West

FOR THE BOARD:

DATE: December 17, 2004

Suzanne Cochran
Chairman

Dissenting opinion of Suzanne Cochran and Elaine Crews Powell

We respectfully dissent.

Travel is an inherent and fundamental component of the "service" provided by home health agencies. Extraordinary travel expense, therefore, falls neatly within the regulatory exception at 42 C. F. R. 413.130(f)(1) for "atypical" services.

The rate setting mechanism established in the same regulation clearly makes "geographical area where services are furnished" a factor in what should be considered in "establishing the cost limits." 42 C.F.R.§413.130(b)(1)(ii). The rate determined is based on areas having similar geographic characteristics. Because the Provider has established that its geographical characteristics are not typical compared to those of HHAs similarly classified, its service is atypical. It was not disputed by the Intermediary or by CMS that the excess cost was due to the patients' remote locations. Moreover, the travel cost and visits statistics that the Provider used in its exception request came directly from the cost report the Intermediary reviewed and found reasonable. Furthermore, we find no basis in Medicare statute or regulations that supports the conclusion that an "atypical services" exception can be interpreted to mean only "atypical direct patient care services."

Suzanne Cochran, Esq.

Elaine Crews Powell, CPA