PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D9

PROVIDER -
Washington County Memorial Hospital
Potosi, Missouri

Provider No.: 26-0039

vs.

INTERMEDIARY -
BlueCross BlueShield Asssociation/
TriSpan Health Services

DATE OF HEARING -
October 6, 2005

Cost Reporting Period Ended -
August 31, 2000

CASE NO.: 04-0412

INDEX

ISSUE:

Whether the Intermediary's computation of the adjustment due the Provider for a decrease in discharges experienced in FY 2000 was correct.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

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

42 C.F.R. §412.108(d) allows favorable reimbursement treatment for Medicare dependant hospitals (MDH) that experience a significant volume decrease. This “low volume adjustment” is available if the MDH can demonstrate that it had more than a 5% decrease in its patient discharges as compared to its immediately preceding cost reporting period and that the decrease was due to circumstances beyond its control.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Washington County Memorial Hospital (Provider) is a “Medicare-dependant,” small rural hospital (SRH) located in Potosi, Missouri that qualified for an additional payment because its discharges decreased more than 5% between 1999 and 2000. That the Provider was entitled to an additional payment is not in dispute; the only dispute is the amount of the additional payment. The Intermediary, TriSpan Health Services, calculated the payment using a manual section applicable to “sole community hospitals.” The Provider argues that this manual section is inapplicable and that the regulation governing “medicare dependant hospitals” must be applied.

It also argues that, even if the manual provision on sole community hospitals was applicable to Medicare dependent hospitals, the Intermediary failed to fully implement those provisions.

The Provider appealed the Intermediary's determination to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by Greg Lepper, of Greensfelder, Hemker and Gale, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary used the provisions of Provider Reimbursement Manual (PRM) 15-1 §2810.1, entitled *Additional Payments to Sole Community Hospitals That Experience a Decrease in Discharges,* to calculate an additional payment of $15,507. Section 2810.1(D) caps the maximum additional payment as the prior year's total Program Inpatient Operating Cost (excluding pass-through costs) increased by the Prospective Payment System update factor. This was exactly how the Intermediary computed the amount that it allowed, and it maintains that the additional payment was properly determined. When the Provider objected to the adjustment, the Intermediary followed the instructions at PRM 2810.1(D) which reads, "Note: If an intermediary determines that the procedures in this section, when applied to a specific adjustment request, generates an anomalous result, the intermediary may request a review by HCFA," and contacted CMS for an opinion regarding the accuracy of its calculation.[1] CMS responded by stating that they were in agreement with the Intermediary's calculation and that there is no exception process for this issue, but the Provider could appeal the adjustment in the same manner that it would for any other Intermediary cost report adjustment.

The Provider, believing that the controlling regulation at 42 CFR §412.108(d)(3) does not contain the inherent cap contained in the Sole Community Hospital (SCH) manual provision utilized by the Intermediary, used the amounts from its settled 2000 cost report to compute " . . . the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs. . ." plus outlier payments, indirect medical education payments, and disproportionate share payments. The costs from the settled cost report had been adjusted by the Intermediary to eliminate excess staff salaries, and the Provider did not object. The result of the Provider's additional payment computation was an amount due of $52,965.

The Provider further avers that if the Intermediary can properly apply the SCH-specific manual provision, it must apply all of it; including whether the Intermediary's calculation created an "anomalous result" that was driven by the fact that the Provider's Medicare discharges decreased at a rate lower than total discharges and the fact that its Medicare average length of stay increased. For the purpose of demonstrating the reasonableness of its $52,965 figure, the Provider included a computation[2] of the impact that the recognition of these issues would have on the Intermediary's 1999-based computation. That computation showed that the additional payment based on the Intermediary's scenario would be $212,212.

[1] Intermediary Position Paper, Exhibit 5
[2] Provider Position Paper, Exhibit 10

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSIONS:

After considering the Medicare law and program instructions, evidence and the parties' contentions, the Boards finds and concludes as follows:

It is undisputed that the Provider is a Medicare-dependant small rural hospital and that its total discharges decreased more than 5% between 1999 and 2000; accordingly, it qualifies for the additional payment provided for in 42 CFR §412.108. 42 CFR §412.108(d)(3) controls this issue, and it sets forth how the additional payment is to be computed.

The Intermediary's reliance on PRM 15-1 §2810.1 to compute the additional payment is misplaced. The Board has ruled previously in Boone County Hospital vs. Blue Cross and Blue Shield Association/Cahaba Government Benefit Administrators, PRRB Dec. No. 2002-D29, August 2, 2002 and Standish Community Hospital vs. Blue Cross and Blue Shield Association/United Government Services, LLC, PRRB Dec. No. 2003-D29, May 14, 2003, that the manual provision applies only to sole community hospitals and not to Medicare dependant hospitals.

The controlling regulation does not specify the cost report from which the figures used in the computation of the additional payment should be taken. The Provider advocates using the year in which the decrease in discharges occurred, FY 2000. The Board finds that this is a reasonable interpretation of the provisions of the controlling regulation, and further, that the Intermediary's reliance on the SCH-specific manual provision that dictates the use of the 1999 cost report and its inherent cap is baseless.

The Provider clearly demonstrated the reasonableness of its computation of the additional payment by using the Intermediary's methodology to compute its figure while giving effect to the variances in Medicare discharges and average length of stay.

DECISION AND ORDER:

The Provider's computation of the additional payment amount due as a result of the decrease in its discharges during FYE 2000 is correct. The Intermediary's determination is reversed.

MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

FOR THE BOARD:

DATE: December 22, 2005

Suzanne Cochran
Chairperson