# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D30

**PROVIDERS -**
Greenbriar Nursing and Convalescent Center
Guest House of Slidell
Riverland Healthcare Center

Provider Nos.: 19-5301; 19-5302
and 19-5304

**vs.**

**INTERMEDIARY -**
Blue Cross Blue Shield Association/
TriSpan Health Services

**DATE OF HEARING -**
November 30, 2004

Cost Reporting Period Ended -
December 31, 1998

**CASE NOs.:** 00-3284; 00-3619 and
01-0598 (respectively)

**INDEX**

ISSUE**:**

Whether the Intermediary's adjustments to reduce the Providers' outpatient therapy costs by 10 percent were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

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.

As a result of the Balanced Budget Act (BBA) of 1997, a number of changes were made to various payment requirements impacting Medicare cost reporting and payment. One such change mandated cost reductions for outpatient therapy services rendered in calendar year 1998. 42 U.S.C. §1395m(k) modified the payment for outpatient therapy services and comprehensive outpatient rehabilitation services furnished during 1998 to be the lesser of the charges imposed for the services or the adjusted reasonable cost less 20 percent of the amount of the charges imposed for such services. Adjusted reasonable costs were defined as reasonable costs reduced by 10 percent.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case involves three skilled nursing facilities (SNFs) located in the state of Louisiana for the cost reporting period ending December 31, 1998. The facilities are: Greenbriar Nursing and Convalescent Center, Guest House of Slidell and Riverland Healthcare (Providers). Each Provider rendered therapy services to inpatients of its facility during the 1998 calendar year. The Providers billed Medicare for the therapy services rendered to their beneficiaries and Medicare reimbursed the Providers for the services rendered under Part A as a part of the Medicare extended care service for patients who qualified, and under Part B for beneficiaries whose Part A benefits were exhausted.

The Providers submitted their cost reports utilizing the charge data from the Provider Statistical Reimbursement Report (PS&R) provided to them by their Fiscal Intermediary. Upon review of the cost reports submitted by each of the Providers, Tri-Span Health Services of Louisiana (Intermediary) reduced the cost related to the Part B outpatient therapy services performed on facility inpatients by 10 percent based on the requirements of 42 U.S.C. §1395m(k). The amount of Medicare reimbursement in controversy is approximately $55,764 for Greenbriar; $23,887 for Guest House of Slidell; and $29,894 for Riverland Healthcare Center.

The Providers appealed the audit adjustments to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Providers were represented by Julie A. Bowman of Copeland, Cook, Taylor & Bush. The Intermediary was represented by James Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers argue that although the therapy claims for the beneficiaries who had exhausted their Part A benefits were billed as Part B services and Medicare accumulated those charges as outpatient charges, the services were rendered to inpatients of the non-certified unit of the SNF and, therefore, were not true outpatient services. The Providers claim that it is evident that the 1998 provisions were meant to govern outpatient therapy and not the type of inpatient services rendered by SNFs to their residents. The Providers state that 42 U.S.C. §1395m(k)(4) precludes outpatient physical therapy and occupational therapy services furnished by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A.

In addition, the Providers contend that the Board has addressed a similar issue in St. Barnabas Hospital vs. Blue Cross and Blue Shield Association/Empire Medicare Services, PRRB Dec. No. 2000-D51, April 27, 2000 Medicare & Medicaid Guide (CCH) ¶80,441, and made the distinction between inpatient and outpatient services. The Board found in St. Barnabas that the outpatient cost reduction factor mandated in the Omnibus Budget Reconciliation Act (ORBA) of 1990, which added §1861 (v)(1)(S)(ii)(II) to the Social Security Act, may not be applied to inpatient Part B hospital services, as those services were in fact furnished to hospital inpatients, not hospital outpatients, and therefore constitute hospital inpatient services, not hospital outpatient services. The Providers argue that the same reasoning should be applied in this matter, and Part B therapy services rendered to inpatients of the SNFs should be deemed inpatient SNF services.

The Intermediary argues that the application of the 10 percent reduction of reasonable costs to outpatient Part B services was required by law and was proper. The Intermediary contends that although the services in dispute were rendered to inpatients of the facilities, for Medicare payment purposes they are considered outpatient services, and therefore would be subject to the 10 percent reduction in 1998.

The Intermediary contends that once a Medicare beneficiary exhausts Part A coverage, even though he/she may still be an inpatient of the SNF, the beneficiary is only entitled to those benefits that any other Medicare beneficiary would be entitled to under Part B, including

outpatient physical therapy.[1] The Intermediary further argues that 42 U.S.C. §1395x(p) defines the term outpatient physical therapy services as including therapy services ". . . furnished to an individual as an inpatient of a hospital or extended care facility." Therefore, the Intermediary asserts that 42 U.S.C. §1395m(k)(4) would apply to the Providers' Part B outpatient therapy services, regardless of whether the beneficiaries were inpatients of the facilities, as the regulation does not preclude services rendered to inpatients of a SNF, only to a hospital.

The Intermediary also asserts that the current case is distinguishable from the St. Barnabas case and the Daniel Freeman Hospital[2] case, as those cases relate to hospitals, not to skilled nursing facilities, and the issue in those cases was the handling of employee services in general as opposed to therapy services which are specifically dealt with in 42 U.S.C. §1395x(p).[3]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, evidence presented and the arguments of the parties, the Board finds as follows:

42 U.S.C. §1395m(k) states in part:

> (k) Payment for Outpatient Therapy Services and Comprehensive Outpatient Rehabilitation Services.
>
> (2) Payment in 1998 based upon adjusted reasonable costs. The amount under this paragraph for services is the lesser of –
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> (A) the charges imposed for the services, or
> (B) the adjusted reasonable costs (as defined in paragraph (4)) for the services, less 20 percent of the amount of the chares imposed for such services.
>
> (4) Adjusted Reasonable Costs. In paragraph (2), the term 'adjusted reasonable costs' means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

For the purposes of the application of the 10 percent reduction mandated above, 42 U.S.C §1395 l(a)(8)(A) describes outpatient services which are subject to the reduction as:

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[1] Transcript, pages 15-17.

[2] Daniel Freeman Memorial Hospital vs. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec 2000-D57, May 31, 2000.

[3] Transcript, page 20.

> (A) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished –
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> (i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,
> (ii) by a home health agency to an individual which is not homebound, or
> (iii) by another entity under an arrangement with an entity described in clause (i) or (ii);

The Board finds that the therapy services in question meet the definition of outpatient physical therapy services as described in 42 U.S.C §1395 l(a)(8)(A), and therefore would be subject to the 10 percent reduction requirement of 42 U.S.C. §1395m(k). The Providers' argument that the focus of the issue should be on the inpatient status of the patient and not on the payment mechanism is without merit, as the statute specifically requires the reduction of outpatient therapy services costs rendered by skilled nursing facilities. The Board also finds the Providers' argument that the Board's ruling in St. Barnabas would apply to this case is without merit as, in this case, there is a specific statute that governs the payment mechanism for therapy services rendered at a SNF, whereas the St. Barnabas ruling applied to hospitals and their payment functions. Therefore, the two cases are not comparable.

DECISION AND ORDER:

The Intermediary's adjustments to reduce the Providers' outpatient therapy costs by 10 percent were proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: June 16, 2006

Suzanne Cochran
Chairperson