PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D28

PROVIDER -
Decatur County General Hospital
Parsons, Tennessee

Provider No.: 44-0070

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrators

DATES OF HEARINGS -
LIVE - March 3, 2005 (Case No.: 03-0513)
RECORD - June 28, 2006 (Case No. 04-0456)

Cost Reporting Periods Ended -
June 30, 2000 and June 30, 2001

CASE NOs.: 03-0513 and 04-0456

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ISSUE:

Whether the FYEs 6/30/00 and 6/30/01 ambulance cost per trip limits were improperly low because the Intermediary improperly applied the 5.8% outpatient operating cost reduction and the 10% outpatient capital cost reduction to base year costs utilized to calculate those limits.

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 portion 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 or PRRB) 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

Decatur County General Hospital (the Provider), a governmental acute care hospital chartered by the State of Tennessee, is located in Parsons, Tennessee. The Provider operates swing beds, a home health agency and a hospital-based emergency medical ambulance service for Decatur County. For the fiscal years at issue, the Provider reported the cost of ambulance services on the cost reports and the Medicare charges for ambulance services on Worksheet D, Part V of the cost reports. As part of the final settlement of Provider's FYE 6/30/2000 and 6/30/2001 cost reports, the Intermediary reduced capital-related costs for outpatient hospital services by 10 percent and outpatient operating costs by 5.8 percent.[1] The Provider disagreed with the application of the

[1] This reduction was built into the software that the Provider used to file the initial cost report and the software used by the Intermediary to finalize the cost report. The

reduction factors to its ambulance services (which were also subjected to cost per trip limits) and filed a timely hearing request with the Board. The amounts in dispute are approximately $19,000 and $130,004 for FYE 6/30/00 and 6/30/01 respectively.

The Provider was represented by Stephen B. Roosa, Esq., of Reed Smith LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.[2]

PROVIDER'S CONTENTIONS

The Provider contends that the Intermediary erred when it applied the 5.8% and 10% reduction factors. The Provider argues that ambulance services have always been treated differently than other outpatient services because they are excluded from the "72 hour rule"[3] under which outpatient services are paid pursuant to an inpatient diagnosis related group (DRG). Also, hospital-based ambulance services are excluded from the outpatient prospective payment system (OPPS); therefore, the fact that the application of these reductions ended upon the adoption of Outpatient PPS is further evidence that Congress did not intend for them to apply to ambulance services.

The Provider also notes that the 5.8% and 10% reduction factors apply to services listed at 42 U.S.C. §1395x(s)(2)(A-D) which define outpatient hospital services. Ambulance services, however, are separately defined at 42 U.S.C.§1395x(s)(7). Accordingly, the 5.8% and 10% reduction factors that apply to outpatient hospital services pursuant to §§1395x(v)(1)(S)(ii) (I and II), do not apply to ambulance services. This is further supported by the fact that 42 U.S.C. §1395x(v)(1)(U), which provides instruction regarding how to calculate the ambulance services cost per trip limit, does not discuss the reduction factors.

The Provider also contends that, irrespective of whether ambulance services qualify as outpatient hospital services pursuant to §§1395x(v)(1)(S)(ii)(I and II), the 5.8% and 10% reduction factors should not have been applied in the base year; rather, the Intermediary should have used the Provider's actual costs for the base year to determine the cost per trip limit. Because the reduction factors were applied to the base year costs, the Provider's ambulance trip reimbursement for the subsequent cost reporting periods was understated.

The Provider explains that 42 U.S.C. §1395x(v)(1)(U), which determines the reasonable cost of ambulance services by establishing a cost per trip limit, is based upon the costs

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Provider filed a protested amount on its cost reports alleging that the reduction of ambulance service reimbursement was improper.

[2] Subsequent to the March 3, 2005 telephonic hearing for Case No. 03-0513, the parties agreed to adjudicate Case No. 04-0456 (FYE 6/30/2001) on the record and to officially incorporate the hearing transcript of March 3, 2005 into Case No. 04-0456. See Intermediary's Amended Final Position Paper (Case No. 04-0456) at Exhibit (Ex) 16.

[3] See 42 U.S.C. §1395ww(a)(4); 42 C.F.R. §§412.2(c)(5).

recognized as reasonable in the prior fiscal year. Accordingly, the statute is based on the premise that a base year exists, and what is recognized is the amount determined as "reasonable cost," as opposed to the amount paid for the previous year. Additionally, 42 U.S.C. §1395(x)(v)(1)(A) defines "reasonable cost" as the cost actually "incurred" (as opposed to the Medicare payment after the reduction). Likewise, the statute which establishes the reduction itself, §1395x(v)(1)(S)(ii) states that the Secretary should reduce the "reasonable costs" as opposed to making a reduction to obtain the reasonable costs. Moreover, Congress only intended these reductions to apply to outpatient operating costs and capital costs that are now covered by outpatient PPS. The Provider claims that a recognizable, discrete, distinction exists between ambulance services and outpatient services subject to the 5.8% and 10% reduction factors.

Finally, the Provider contends that the Intermediary erroneously applied the ambulance cost per trip limits in determining its ambulance cost reimbursement for FYE 2001. The Reimbursement methodology should have been based on full cost reimbursement without any limitations and without the 5.8% and 10% cost reduction factors as the statute at 42 U.S.C. §1395(v)(1)(U) states that the cost per trip limit only applies prior to January 1, 2000. If Congress had intended for the cost per trip limits to continue to apply until Outpatient PPS was actually implemented, it would have said so, rather than stating a specific cut off date.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the 5.8% and 10% cost reduction provisions of the Social Security Act apply because under 42 U.S.C. §1395(x)(s)(7) patients transported by ambulance (with the exception of patients being transported between hospitals) are outpatients covered under Part B. Although the Intermediary does not dispute the Provider's contention that ambulance services are treated differently from other outpatient services in certain situations, that different treatment alone does not dictate redefining ambulance services as something other than an outpatient service.

Section 1861(v)(1)(S)(ii)(III) of the Social Security Act, which provides for an exception for the cost reduction provisions applicable to the costs of outpatient services provided by critical access hospitals and sole community hospitals, does not apply to this Provider. Additionally, the cost per trip limit was reported correctly in the base year as including the 5.8% and 10% reductions. That reported amount is the reasonable cost for purposes of establishing the base year.

The Intermediary explains that the Balanced Budget Act (BBA) indicates that the fee schedule was to be effective for ambulance services on or after January 1, 2000 and that CMS, through its September 12, 2000 proposed rule, indicated its intention to implement the schedule beginning January 1, 2001. However, the fee schedule was not actually implemented until April 1, 2002. In spite of this fact, the Intermediary contends that the reimbursement for ambulance services should not revert back to pre-BBA cost reimbursement for FYE June 30, 2001 because this treatment would undermine Congressional intent to limit the cost of ambulance services.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, evidence presented and the parties' contentions, the Board concludes that the ambulance services at issue are subject to the 5.8 percent and 10 percent reduction factors, although such reduction factors should not be applied to the base year.

42 USC §1395x(v)(1)(S)(ii) provides that such reduction factors be applied to outpatient hospital services:

> (I) . . . in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter . . . by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1395*l*(t) of this title is implemented (emphasis added).
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> (II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than capital-related costs of such services) otherwise determined pursuant to section 1395*l*(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1395*l*(t) is implemented (emphasis added).

Pursuant to the Balanced Budget Act of 1997 (42 U.S.C. §1395x(v)(1)(U)), Congress enacted the following cost per trip limit to determine the reasonable cost of ambulance services.

> In determining the reasonable cost of ambulance services . . . provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year . . . increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point.

Additionally, 42 U.S.C. §1395x(s)[4] has seventeen subsections that define medical and other health services. Subsection (7) defines ambulance services as medical and health services. The Board agrees with the Provider that four of the twenty-two subparts (§§A-D) of subsection (2) of 42 USC §1395(x)(s) *clearly describe* "outpatient hospital services." However, the Board finds no merit or authority for the Provider's contention that these four subparts *exclusively* define "outpatient hospital services." Thus, the Board finds that the ambulance services at issue are subject to the 10% and 5.8% reduction factors.

As further evidence that the ambulance services at issue are outpatient hospital services, (although not covered under Outpatient PPS), 42 U.S.C.§1395*l* states, in relevant part:

> …(t) Prospective payment system for hospital outpatient department services—
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> (1) Amount of payment. . . .
> (B) Definition of covered OPD services
> For purposes of this subsection, the term "covered OPD services"--…
> (iv) does not include…ambulance services, for which payment is made under a fee schedule described in section 1395m(k) of this title or section 1395m(l) of this section. . .
> (10) Special rule for ambulance services
> The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1395x(v)(1)(U) of this title, or, if applicable, the fee schedule established under 1395m(l) of this title (emphasis added.)

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[4] 42 U.S.C. §1395x(s) states, in relevant part

(s) The term "medical and other health services" means any of the following items or services:

(2) (A) services and supplies…furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians bills;

(B) hospital services… incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangement with them made by a hospital, and

(ii) ordinarily furnished by such hospital…to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services and outpatient occupational therapy services;

(7) ambulance service where the use of other methods or transportation is contraindicated by the individual's condition, but . . . only to the extent provided in regulations.

42 C.F.R. §419.22 states:

> Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.
>
> The following services are not paid for under the hospital outpatient prospective payment system:
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> (i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule under section 1834(l).

Accordingly, the Board finds that the ambulance services at issue are subject to the 5.8% and 10% reduction factors, as they are outpatient hospital services.

Regarding whether the costs recognized as reasonable in the base year should include the application of the 5.8% and 10% reduction factors, the Board agrees with the Provider that the reductions should not be applied to the base year. The Board also agrees with the Provider that 42 U.S.C §1395x(v)(1)(S) and the statutory scheme support the premise that the 5.8% and 10% reductions are made to arrive at reasonable costs.[5]

The Board also finds that no statutory or regulatory provision extended the cost per trip limits beyond January 1, 2000. 42 U.S.C. x(v)(1)(U), which establishes the cost per trip limit, states:

> In determining the reasonable cost of ambulance services (as described in subsection (s)(7) of this section) provided during fiscal year 1998, during fiscal year 1999 and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year . . .

Accordingly, for the FYE June 30, 2001 cost reporting period, the Provider is entitled to be reimbursed for reasonable costs for FYE 2001 without the application of the cost per trip limit.

DECISION AND ORDER:

The Intermediary improperly applied 5.8% outpatient operating cost reduction and10% outpatient capital cost reduction to base year costs used to calculate the Provider's FY 2000 ambulance cost per trip limits.

The Provider is entitled to costs reimbursement for ambulance services provided during FYE 6/30/2001 (subject to the 5.8 percent and 10 percent reductions). No ambulance cost per trip limits are to be applied. The Board hereby remands this case to the

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[5] See also 42 U.S.C. §§1395(x)(v)(1)(A)and (U).

Intermediary to recalculate the ambulance cost per trip limits accordingly and to modify its adjustments.

BOARD MEMBERS PARTICIPATING:

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

DATE: April 20, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson