PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D41

PROVIDER -
Munson Medical Center
Traverse City, Michigan

Provider No.: 23-0097

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - WI

DATE OF HEARING -
September 4, 2007

Cost Reporting Period Ended -
June 30, 2002

CASE NO.: 06-0614

INDEX

ISSUE:

Whether the Intermediary correctly limited the Provider's ambulance reimbursement to its charges.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.9, 413.20 and 413.24.

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) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services, subject to principles relating to specific items of revenue and cost.

Pursuant to 42 U.S.C. §1395f(b) and 42 U.S.C. §1395l(a), payment for Medicare Part A and Part B services is based upon the lesser of the reasonable cost of the services as determined by 42 U.S.C. §1395x(v) or a provider's customary charges for the services. This reimbursement limitation is generally known as "the lesser of cost or charges" or the LCC principle of reimbursement, and is set forth in 42 C.F.R. §413.13. The LCC principle was established to ensure that the program would not pay more for patient services than rates paid by the general public.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Munson Medical Center (Provider) is an acute care hospital located in Traverse City, Michigan. The Provider operates ambulance services that are furnished to Medicare beneficiaries. Under

new regulations effective April 1, 2002, Medicare's method of payment for ambulance services provided by hospitals changed from a reasonable cost methodology to payment based on a fee schedule methodology. The new fee schedule methodology was implemented over a 5-year transition period. During that transition, program payments were made based upon a blend of a hospital's actual incurred costs and an established fee schedule amount. In the first year of the transition the blend consisted of 80 percent of a provider's costs and 20 percent of the fee schedule amount; in year two the blend changed to 60 percent provider costs and 40 percent fee schedule; and, in the remaining three years the blend changed to 40 percent/60 percent then 20 percent/80 percent until reaching 100 percent of the fee schedule in year 5.[1]

National Government Services (Intermediary) reviewed the Provider's cost report for its fiscal year ended June 30, 2002, of which only three months were affected by the new ambulance reimbursement methodology. In determining the Provider's reimbursable costs, the Intermediary applied Medicare's LCC limitation to the Provider's otherwise reimbursable Medicare Part B costs. In applying the LCC limitation, the Intermediary followed established cost report procedures aggregating the costs and charges of all applicable Medicare Part B cost centers, which included the Provider's ambulance cost center. The Provider asserts that the ambulance cost center should not be subjected to the LCC limitation based upon its reading of the new ambulance reimbursement regulations. The inclusion of the ambulance cost center in the Intermediary's LCC application resulted in a reduction in the Provider's reimbursement.

The Provider appealed the Intermediary's determination to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $55,000.

The Provider was represented by Steven Leach, Reimbursement Manager, Munson Medical Center. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary contends that it properly applied Medicare's LCC principle to the Provider's total blended reimbursement amount for ambulance services, i.e., the cost portion of the blended rate as well as fee schedule portion. The Intermediary asserts that 42 C.F.R. §413.118(c) and 42 C.F.R. §413.122(b), which pertain to ambulatory surgical center procedures and hospital outpatient radiology and other diagnostic services, respectively, illustrate that the LCC principle also applies to services that may not be reimbursed on the basis of reasonable cost; rather, these services are reimbursed based upon the lesser of reasonable cost or charges or a blended rate based in part on hospital-specific data.[2]

The Intermediary also contends that the LCC principle is clearly a factor in determining program payments under Medicare's fee schedule reimbursement methodology for hospital furnished ambulance services. 42 C.F.R. §414.610, entitled Basis of payment, states:

[1] Implementing regulations are found at 42 C.F.R. §414.601ff.
[2] Intermediary's Supplemental Position Paper p. 4-5. Exhibit I-4.

> (a) *Method of payment*. Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment for ambulance services equals a base rate for the level of service plus payment for mileage and applicable adjustment factors. Except for services furnished by certain critical access hospitals or entities owned and operated by them, as described in §413.70 (b) of this chapter, all ambulance services are paid under the fee schedule specified in this subpart (regardless of the vehicle furnishing the service). (Emphasis added.)

Moreover, 42 C.F.R. §414.615, entitled Transition to the ambulance fee schedule, states in part:

> The fee schedule for ambulance services will be phased in over 5 years beginning April 1, 2002. Subject to the first sentence in §414.610(a), payment for services furnished during the transition period is made based on a combination of the fee schedule payment for ambulance services and the amount the program would have paid absent the fee schedule for ambulance services . . . (Emphasis added).

The Provider cites 42 C.F.R. §414.615(a), asserting that it succinctly establishes hospital based ambulance reimbursement during the transition period, as follows:

> (a) 2002 Payment. For services furnished in 2002, the payment for the service component, the mileage component and, if applicable, the supply component is based on 80 percent of the reasonable charge for independent suppliers or on 80 percent of reasonable cost for providers, plus 20 percent of the ambulance fee schedule amount for the service and mileage components. The reasonable charge or reasonable cost portion of payment in CY 2002 is equal to the supplier's reasonable charge allowance or provider's reasonable cost allowance for CY 2001, multiplied by the statutory inflation factor for ambulance services.

The Provider also contends that even if the Board were to find that Medicare's LCC principle was applicable to ambulance payments made during the transition period, it should only be applied to the fee schedule portion of the program's payments since, as mentioned above, 42 C.F.R. §414.615 pertains only to fee schedule amounts.[3]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary properly limited the Provider's ambulance reimbursement to its charges. Medicare's LCC principle of reimbursement applies to both the cost portion and the fee schedule portion of ambulance reimbursement throughout the transition period at 42 C.F.R. §414.615.

[3] Transcript (Tr.) at 26.

The first sentence of 42 C.F.R. §414.610(a) clearly explains that the LCC principle applies to the fee schedule amount; it states, "Medicare payment for ambulance services is based on the lesser of the actual charge or the applicable fee schedule amount" (emphasis added). Therefore, the question raised is whether the LCC principle applies to transition year payments, and if so, whether it applies to the cost portion or the fee schedule portion of the payments or both. The Board finds that these questions are answered by 42 C.F.R. §414.615 which states that payments made during the transition period are "[s]ubject to the first sentence in §414.610(a)."

After a complete reading, the Board concludes that 42 C.F.R. §414.615 requires the LCC principle be applied to program payments made for ambulance services throughout the transition period. The regulation provides that transition period payments are made based on a combination of the fee schedule amount and "the amount the program would have paid absent the fee schedule for ambulance services." It is undisputed that payments made in the absence of, or prior to, the fee schedule methodology would be subject to the LCC limitation.

For the reasons stated above, the Board disagrees with the Provider's argument that 42 C.F.R. §414.615(a) succinctly establishes hospital based ambulance payment during the transition years, completely independent of other regulations. If that were the case, the Board believes the ambulance regulations at 42 C.F.R. §414.601ff would have explicitly addressed this matter.

Finally, Medicare has applied the LCC principle to reimbursement methodologies similar to that of the ambulance fee schedule. For example, 42 C.F.R. §413.118(c), which pertains to ambulatory surgical center procedures, shows that Medicare applies the LCC limitation where program payments are made, based on the lower of reasonable cost or a blended rate comprised of hospital-specific data and rates paid to free-standing ambulance surgical centers.[4]

DECISION AND ORDER:

The Intermediary correctly limited the Provider's ambulance reimbursement to its charges. Medicare's LCC limitation applies to both the cost portion and the fee schedule portion of program payments made for ambulance services throughout the transition period at 42 C.F.R. §414.615.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A. (inactive)

[4] The Intermediary also cited 42 C.F.R. §413.122(b) applying the LCC limitation to program payments made for hospital outpatient radiology and other diagnostic services.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 29, 2008