# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D11

**PROVIDER –**
Marion General Hospital

Provider No.: 15-0011

**vs.**

**INTERMEDIARY -**
BlueCross BlueShield Association/
National Government Services, Inc.

**DATE OF HEARING -**
December 6, 2011

Cost Reporting Period Ended -
June 30, 2005

**CASE NO.:** 10-0236

**INDEX**

ISSUE:

Whether the Medicare Administrative Contractor's (MAC) denial of Marion General Hospital's Sole Community Hospital Low Volume Adjustment was proper based on procedural and timing requirements.

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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[3] Each 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").[4] 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 receipt of the NPR.[5]

Part A of the Medicare program covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7] The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[8]

The regulation at 42 C.F.R. § 412.92 establishes the Medicare program criteria that must be met in order for a hospital to be classified as a sole community hospital ("SCH") and sets forth the special treatment for SCHs.[9] CMS adjusts the PPS rates for SCHs to accommodate their special

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 – 405.1837.
[6] *See* 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412.
[7] *See id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C.§§ 1395ww(d)(5)(D)(iii)-(iv).

operating circumstances (*e.g.*, isolated location, weather/travel conditions, unavailability of other hospitals) and also allows special treatment for facilities that qualify as a SCH.

42 U.S.C. § 1395ww(d)(5)(D)(ii) specifies that SCHs shall receive a low volume adjustment ("LVA") in certain qualifying situations that involve a decrease in inpatient cases of more than 5 percent during a cost reporting period:

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts . . . as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

To qualify for an LVA, 42 C.F.R. § 412.92(e) specifies that the provider must meet the following criteria:

> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease.* (1) For cost reporting periods beginning on or after October 1, 1983, the intermediary provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the intermediary must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement —
>
> (i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and
>
> (ii) Show that the decrease is due to circumstances beyond the hospital's control.

The issue in this case involves the timeliness of the Provider's request for an LVA.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Marion General Hospital ("Provider") is an acute care, not-for-profit hospital located in Marion, Indiana. The Provider's Medicare cost report was finalized on December 7, 2006 with the issuance of the initial NPR. At the time of the initial NPR, the Provider had a pending dispute regarding the effective date of its SCH status. The Provider was granted status as an SCH beginning on July 16, 2004 pursuant to Board Decision No. 2008-D1. As a result of that decision, the Provider's cost report was revised on July 8, 2008 ("second NPR"). The June 30, 2005 cost report was revised again on November 19, 2008 ("third NPR") to reduce pension costs and capital disproportionate share ("capital DSH") payments.

On May 11, 2009, the Provider requested a low volume adjustment for the cost reporting period ending June 30, 2005 based on the settlement of the third NPR dated November 19, 2008. The Intermediary denied this request as untimely on June 19, 2009. The Provider timely appealed this denial to the Board on December 10, 2009.

The Provider was represented by Maureen O'Brien Griffin, Esq., of Hall, Render, Killian, Heath & Lyman, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., of the BlueCross BlueShield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that LVAs are governed by very specific statutes and regulations.[10] The Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), includes provisions discussing what the LVA is, who is eligible, what documentation needs to be submitted for approval, how a determination is made, how the adjustment is calculated, and what reconsideration or appeal avenues are available to the Provider after a determination is made.[11] Because of the detail involved, the LVA regulation and the corresponding Manual provisions were intended to be a stand-alone set of instructions. Therefore, the Provider contends that the LVA regulations, not the reopening regulations,[12] should be the controlling authority regarding the issue under appeal.

The PRM 15-1 § 2810.1(C) states that the provider must request the LVA within "180 days of the date on the intermediary's Notice of Program Reimbursement," and it does not distinguish between initial and revised NPRs for requesting this adjustment. Similarly, the LVA regulation does not distinguish between an original and a revised NPR. The Provider, therefore, argues that the appropriate revised NPR to request the LVA was the third NPR dated November 19, 2008.

Although the Provider believes that the only governing authority is the LVA regulations and manual provisions, assuming arguendo that the reopening regulations do apply, the Provider asserts that it filed its LVA request timely from the third NPR dated November 19, 2008.

The Provider states that it was unable to request the LVA within 180 days from the initial NPR because the Provider's SCH status, a critical LVA criterion, was unresolved at the time. The

[10] 42 U.S.C. 1395ww(d)(5)(G)(iii); 42 C.F.R. § 412.92(e).
[11] CMS Pub 15-1 § 2810.1.
[12] 42 C.F.R. § 405.1885.

Provider also argues that the second NPR contained adjustments that were completely unrelated to the LVA request and, as a result, the Provider could not use the second NPR as a basis to request the LVA. As the third NPR issued adjustments to pension costs, a LVA benchmark criterion, it was an appropriate mechanism from which to request the LVA in accordance with the reopening regulations.

The Provider does not believe that this appeal should be held to the reopening regulation above. However, if the Board finds that it is, the Provider reasons that, consistent with the Board decision in *Stanislaus Medical Center v. BlueCross BlueShield Association* ("*Stanislaus*"),[13] the third NPR "touches on the same subject matter under appeal" and can, therefore, be subject to appeal. The Provider reasons that the third NPR revised the pension costs that directly affects the inpatient costs which are one of the components reviewed to determine an LVA.

Not only are inpatient costs associated with LVA eligibility, but they are also related to the overarching principles behind the LVA. The PRM 15-1 § 2810.1 states that the LVA payment is made to an SCH for "fixed costs it incurs in the period in providing inpatient hospital services . . . but not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG payments."

The Provider reasons that the comparison of inpatient costs to DRG payments is analogous to the five percent decrease in discharge requirement. That is, if the decrease in discharges is less than five percent, the LVA will not be considered and no calculation is necessary. Similarly, if the DRG payments exceed inpatient cost, the LVA will not be considered and an LVA calculation is not necessary. Although inpatient costs come into play when calculating the LVA, they are also critical in determining eligibility for the LVA. The Provider argues that, due to the significant two-fold role inpatient costs play in the LVA request process, the adjustment of these costs in the third NPR must serve as the Provider's platform to request the LVA.

The Provider concludes that, pursuant to 42 CFR § 405.1867, the Board must comply with the statute and regulations. These take precedence over any Administrator's decision such as the one that overturned the Board in *Stanislaus*[14] to which the Board must only give deference. The Provider surmises that, since 42 U.S.C. § 1395ww(d)(5)(D)(ii) does not specify any timeframe in which an SCH must request an LVA, Congress did not want it to be difficult or restrictive for SCHs to obtain relief from decreases in patient volume due to circumstances beyond their control.[15]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the requirements under PRM 15-1 § 2810.1(A) state the criteria for receiving an LVA:

- Circumstances beyond the provider's control and .

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[13] PRRB Decision No. 1998-D79 (July 30, 1998), *rev'd*, Administrator Dec. (July 30, 1998).

[14] *See supra* note 16.

[15] *See* Provider's Supplemental Position Paper at 3.

- A decrease of more than five percent in discharges.

If the provider does not meet these criteria, no further calculations are made.

The Intermediary notes that the third NPR dated November 19, 2008 did not adjust the total discharges on the cost report's Worksheet S-3 even though there was an error in the total discharges reported on the Medicare cost report that was not noticed by the Intermediary or the Provider. The Intermediary asserts that, if total discharges were incorrect on the cost report, the Provider could have requested a reopening on this issue but did not.

Instead, the Intermediary argues that the Provider based its ability to challenge the pension payment adjustment as a way to also challenge its eligibility for the LVA. The Provider has simply seized upon the "touched on" language in the Board's decision in *Stanislaus* to justify using the third NPR to request the LVA. The Intermediary reasons that the Provider must first be determined eligible for the LVA before any further calculation can be made. Since the Provider was not eligible for the LVA, there is no basis for an appeal in this case.

The Intermediary cites to the Board's 2009 decision in *St. Joseph's Hospital and Health Center*,[16] as applied to Marion to argue that the LVA opportunity arose from the second NPR dated July 8, 2008 which enlarged the SCH period from five months to twelve months. Contrary to the Provider's assertion, this critical LVA opportunity was present only in the second NPR and the Provider should have requested the LVA by early January 2009. Because the Provider did not appeal from the second NPR, the Provider missed its chance by waiting until May 11, 2009 to request the LVA. Therefore the Provider's request was untimely.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence submitted, finds and concludes that the Intermediary properly denied the Provider's LVA request due to its untimely filing.

The Board finds the regulation at 42 C.F.R. § 412.92(e) language is clear and direct on its face. It states that an SCH's LVA request must be submitted to the Intermediary no later than 180 days after the date of the NPR. The Board finds the following facts as undisputed:

(1) The date of the original NPR was December 7, 2006 .
(2) The date of the Board's Decision No. 2008-D1 was October 10, 2007 (giving the Provider SCH status effective July 16, 2004).
(3) The date of the second NPR was July 8, 2008 (changing the SCH effective date from February 4, 2005 to July 16, 2004).
(4) The date that the Intermediary reopened the second NPR was September 11, 2008.
(5) The date of the third NPR was November 19, 2008 (adjusting the pension costs and capital DSH).

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[16] PRRB Dec. No. 2009-D15 (Apr. 1, 2009), *declined review*, Administrator (June 2, 2009).

(6) The Provider requested LVA on May 11, 2009.
(7) The Intermediary denied the LVA request on June 19, 2009.
(8) The Provider appealed the denial on December 10, 2009.

The Board agrees that the Provider was unable to request the LVA after the initial NPR because there was a dispute regarding the effective date of SCH status and, without knowing when SCH status is effective, a provider cannot determine whether it is entitled to an LVA. However, the Board disagrees that the proper NPR from which to appeal was the third NPR dated November 19, 2008.

The Board determines that the Provider should have appealed from the second NPR as this was the proper NPR to request the LVA. At the outset, the Board notes that the second NPR is a "revised determination" and that the regulations governing appeals of revised determinations are applicable and must be read in conjunction with 42 C.F.R. § 412.92(e). The applicable rules governing appeals of revised determinations are located in 42 C.F.R. § 405.1889(b) and they limit any appeal of a revised determinations to those matters revised by that revised determination. Pursuant to § 405.1889(b), the Provider would have been able to appeal from the second NPR because, between the first NPR and the second NPR, the Provider resolved its SCH status for the cost reporting period at issue and the second NPR changed the effective date of the Provider's SCH status.[17] Indeed, as recognized by the Provider, the second NPR was issued to pay additional Transitional Outpatient Payments ("TOPs") to the Provider as a result of the Provider being successful in the dispute over its SCH status.[18] Thus, contrary to the Provider's contention, the second NPR directly related to the SCH status which is the basis for a provider to request an LVA.

The Provider's argument that the only NPR to open the LVA request window was the third NPR is unpersuasive. The record confirms that the reopening that led to the third NPR was done in order to "adjust the pension costs to allowable amounts per Medicare regulations."[19] The record also suggests that the Intermediary's focus on pension costs was related to the direct impact that they have on TOPS payments.[20] Unlike the second NPR, the third NPR does not reflect a change in the Provider's status as an SCH. Moreover, there was no adjustment to the as-filed discharges which is a data point in determining whether an SCH qualifies for an LVA.[21] As the third NPR neither changed the character of the Provider's SCH status nor changed the Provider's as-filed discharges, the Board finds that 42 C.F.R. §§ 405.1889(b) prevents the Provider from appealing the LVA issue from the third NPR.[22]

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[17] *See* Provider's Supplemental Position Paper at 2.
[18] *See* Provider's Final Position Paper at 2 ("The Provider was issued its Transitional Outpatient Payments (TOPs) for its SCH status via this Second NPR."); Provider Post-Hearing Brief at 1 ("NPR2 was issued to pay additional Transitional Outpatient Payments ('TOPs') when the Provider's effective date for SCH status was made retroactive after winning their appeal on that issue.").
[19] Provider Exhibit P-8.
[20] *See* Provider Exhibit P-9 (Intermediary LVA determination for FYE June 30, 2006 dated Nov. 19, 2008).
[21] While pension costs do have an effect on inpatient costs, this is not the prevailing determination for an LVA request. 42 C.F.R. § 412.92(e) and PRM 15-2 § 2810.1 both state that the provider must show a five percent decrease in discharges. Only after a provider can show the five percent decrease in discharges will inpatient operating costs come into play for the calculation of the LVA.
[22] The Board notes that, as the reopening that led to the third NPR occurred after August 21, 2008, then the final rule that was issued on May 23, 2008 and amended 42 C.F.R. § 405.1889 is applicable to the third NPR. *See* 73 Fed.

Finally, the Board notes that the Provider has stated a number of times that the discharges were incorrect on its as-filed Medicare cost report and that, on May 11, 2009, the Provider made a request to reopen the cost report to correct this error.[23] The Board could find no evidence that the Provider made a request to the Intermediary to correct this data or that the Intermediary reviewed and denied this request. Therefore, the only opportunity to request the LVA was from the second NPR dated July 8, 2008, which was almost a year after the Provider received SCH status.

Based on the above findings, the Board concludes that the Intermediary acted properly in denying the Provider's LVA request due to its late filing.

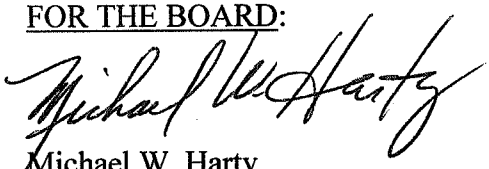
DECISION AND ORDER:

The Intermediary properly denied the Provider's LVA request due to late filing. The Intermediary's denial is affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: APR 23 2013

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Reg. 30190, 30266-30267 (May 23, 2008). The amended regulation states in § 405.1889(b)(2) that "[a]ny matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision."

[23] *See, e.g.*, Provider's Final Position Paper at 3.