PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D71

PROVIDER -
Benewah Community Hospital
St. Maries, Idaho

Provider No. 13-0037

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Oregon

DATE OF HEARING-
February 18, 2000

Cost Reporting Periods Ended -
September 31, 1991,
September 31, 1992

CASE NOS. 95-1279 & 95-1280

INDEX

ISSUE:

Were the Intermediary=s adjustments disallowing costs associated with the Certified Nurse Anesthetist proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider received pass-through treatment of its Certified Registered Nurse Anesthetist (CRNA) costs for 1991 and 1992. However, in 1994 the Intermediary noticed that the Provider had not provided required documentation before the beginning of 1991(regarding its volume of procedures requiring anesthesia). The Intermediary then reopened the September 30, 1991 cost reports to recoup the pass-through payments.[1] During the audit of the September 30, 1992 cost report, the Intermediary noted that the Provider again failed to file a request for Intermediary approval of its CRNA pass-through costs. An adjustment was made to recoup those costs.[2] The issue in contention is whether the Provider should be granted an exception to the CRNA fee schedule and receive pass-through payments even though it failed to notify the Intermediary of its intention to continue receipt of those payments.

The Provider appealed the Intermediary=s adjustments to the Provider Reimbursement Review Board (ABoard@) and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The amount in controversy is $53,637. The Provider was represented by Eric D. Moro, CPA of LeMaster & Daniels, PLLC. The Intermediary was represented by James R. Grimes, Esquire of the Blue Cross and Blue Shield Association.

Statutory Background:

Public Law 99-509, OBRA of 1986, Section 9320 (j) and (k)
states as follows:

> . . . (k) Authorization of Continuation of Pass-Through.--
>
> (1) Subject to paragraph (2) the amendments made by this section shall

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1 Exhibits I-13, I-14.

2 Exhibit I-15.

> not apply during a year (beginning with 1989) to a hospital located in a rural area (as defined for purposes of section 1886(d) of the Social Security Act) if the hospital establishes, at any time before the year, to the satisfaction of the Secretary of Health and Human Services that--
>
> (A) as of January 1, 1988 the hospital employed or contracted with certified registered nurse anesthetist (but not more than one full-time equivalent certified registered nurse anesthetist).
>
> (B) in 1987 the hospital had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services that did not exceed 500 (or such higher number as the Secretary determines to be appropriate), and
>
> (C) each certified registered nurse anesthetist employed by, or under contract with, the hospital has agreed not to bill under part B of title XVIII of such Act for professional services furnished by the anesthetist at the hospital.
>
> (2) Paragraph (1) shall not apply in a year (after 1989) to a hospital unless the hospital establishes before the beginning of the year, that the hospital has had a volume of surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services in the previous year that did not exceed 500 (or such higher number as the Secretary determines to be appropriate).[3]

Also, there were various amendments[4] to this section, which include the following:

1. The 1988 Amendments added the above-quoted section (k), effective October 13, 1988, through Section 608(c)(2) (technical corrections section) of the Family Support Act of 1988 (Public Law 100-485).

2. The 1989 Amendments per Section 6132 of OBRA 1989 (Public Law 101-239), applicable to services furnished after December 31, 1989,

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[3] See Intermediary Exhibit I-1

[4] Id.

which:

* substituted "500" for "250" each place it appeared in subsection (k),

* substituted "a year (beginning with 1989) for "1989, 1990**,** and 1991" in subsection (k)(1),

* substituted "at any time before the year" for "before April 1, 1989" in subsection (k)(1),

* substituted " in a year (after 1989)" for "1990 and 1991" in subsection (k)(2)

* substituted "the year" for "each respective year" in subsection (k)(2), and

* deleted paragraph (3).

HCFA announced in the January 26, 1989, Federal Register, (54 Fed. Reg. 3805) that Section 9320 of Public Law 99-509 was amended by Section 608(c) of Pub. Law 100-485 to allow certain hospitals located in rural areas to continue to be reimbursed on a reasonable cost basis for CRNA services during calendar years 1989, 1990 and 1991.[5]

HCFA also informed the providers of services and fiscal intermediaries, via various HCFA Manual Transmittals, regarding the changes in the reimbursement of CRNA services furnished on or after Jan. 1, 1990, and the related reimbursement instructions.[6]

The Intermediary, through its Medicare Bulletins 90-24 dated February 5, 1990, 92-08 dated March 16, 1992, and 93-01 dated November 20, 1992, also informed the providers of services of changes in the reimbursement for CRNA services furnished on or after Jan. 1, 1990.[7]

In the July 31, 1992 Federal Register, (57 Fed. Reg. 33878) HCFA announced that it revised the Medicare regulations effective for services furnished on or after January 1, 1989, to implement section 9320 of OBRA 1986.

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[5] Exhibit I-2.

[6] Exhibits I-3 through I-9.

[7] Exhibit I-10.

In March 1994, HCFA revised the Medicare Intermediary Manual, HCFA Pub. 13-3 ' 3660.9 to state:

> . . . [A] rural hospital that qualified and was paid on a reasonable cost basis for CRNA . . . . during calendar year 1989 can continue to be paid on a reasonable basis for these services furnished during calendar year 1990 if it can establish before January 1, 1990 that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during 1989....
>
> [A] rural hospital can qualify and continue to be paid on a reasonable cost basis for qualified CRNA ... services for a calendar year beyond 1990 if it can establish before January 1 of that year that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during the preceding year. For calendar years beyond 1990, it must make its election after September 30 but before January 1. Determine the number of anesthetics by annualizing the number of surgical procedures for the 9-month period ending September 30 .... [8]

PROVIDER=S CONTENTIONS:

The Provider contends that it received notification dated March 26, 1990, from the Intermediary that it met the requirements for the rural hospital exception.[9] The Provider further contends that the Intermediary continued to pay the Provider CRNA pass-through amounts even though the Provider failed to meet the deadline for annually renewing the CRNA exception. It is the Provider=s assertion that the continuance of CRNA payments led the Provider to believe that nothing was wrong.

The Provider points to the Intermediary witness who testified that the final determination is made at the time the Notice of Program Reimbursement is issued, and that the mere receipt of pass-through payments is not always indicative that the exception had been met. In the instant case, it was not until 1994 that the Intermediary noticed that the required notification had never been received from the Provider.

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[8] Exhibit I-12.

[9] Provider Exhibit 9.

The Provider also contends that the Intermediary has the power to waive the notification requirement, in that the Intermediary did waive the requirement for calendar year 1992.[10] The Provider also asserts that it has met the intention of the law. It was not until 1992 that it was clear that the Provider must notify the Intermediary in writing prior to the beginning of each calendar year that it wishes to continue receiving pass-through reimbursement.

The Provider contends that in Medicare Bulletin 92-08 (Issued March 16, 1992 by the Intermediary) the second paragraph indicates that no documentation or notification is required for 1992 to continue to receive pass-through payments.[11] Since the Provider was already receiving CRNA payments it believed no action was required. Given theses circumstances, the Intermediary has set precedence that notification is not required in all cases.
Finally, the Provider states that it met the requirement for the year prior to the years at issue, and it has met the rule every year from 1993 forward. Since the Provider did not bill the Part B carrier for these services, the Intermediary denial results in the provision of services to Medicare and Medicaid beneficiaries without compensation. The fair thing for the Intermediary to do was to ask the Provider for the notification at the time it was noticed to be missing.

INTERMEDIARY=S CONTENTIONS:

The Intermediary argues that the statutory language, establishing a right to pass-through treatment for CRNA costs, sets out a two step test. First, a hospital seeking initial qualification to receive CRNA costs as a pass-through must establish that it employed or contracted with CRNAs; that in 1987 the hospital had a volume of surgical procedures requiring anesthesia that did not exceed 500; and that the CRNAs did not bill for services under Part B. The second step requires that the hospital that initially qualifies to receive pass-through treatment of CRNA costs must establish, prior to the start of each subsequent year, a continuing right by virtue of the fact that it provides less than 500 surgical procedures requiring anesthesia.

The Intermediary contends the statute clearly requires that the Provider must annually update its data relating to the number of surgical treatments at the Provider in order to continue to receive pass-through

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[10] Provider Exhibit 13.

[11] Id.

treatment. The Provider was aware or should have been aware, of the statutory requirement. Nonetheless, the Intermediary also issued bulletins advising providers of the need to update the data annually in order to continue pass-through payment. In addition, the Provider has outside consultants who were aware of the fact that the Provider would need to annually update its surgical procedure volume data.

The Intermediary further contends that hospitals must be aware of their duties and responsibilities under the Medicare program. It is not the responsibility of the Intermediary to advise individual providers as to their responsibilities.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - Social Security Act:

   ' 1886(d) - PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS.

2. Other Statutes:

   Public Law 99-509, OBRA 1986, Section 9320 (j)(k).

   Public Law 100-485, Family Support Act of 1988, Section 608(c)(2).

   Public Law 101-239, OBRA 1989 Amendments, Sections 6106, 6107& 6132.

3. Regulations - 42 C.F.R.

   '' 405.1835-.1841 - Board Jurisdiction

4. Program Instructions - Medicare Intermediary Manual, (HCFA Pub. 13-3)

   ' 3660.9 - Payment for CRNA Services

5. Other Instructions:

   Intermediary Medicare Bulletin 90-24, February 5,1990

   Intermediary Medicare Bulletin 92-08, March 16, 1992

   Intermediary Medicare Bulletin 93-01, November 20, 1992

6. Federal Register:

54 Fed. Reg. 3805 (January 26, 1989)

57 Fed. Reg. 33878 (July 31, 1992)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, program instructions, parties= contentions, evidence presented, testimony at the hearing, and posthearing briefs, finds and concludes as follows:

The Board finds that the statutory requirements found in Public Law 99-509 ' 9320 (k) clearly establish that a hospital seeking to continue receiving CRNA costs on a pass-through basis must establish, before the beginning of each year, that it had a volume of surgical procedures requiring anesthesia that did not exceed 500. The Board notes that the rules governing the CRNA pass-through costs provide for approval on a calendar year basis, while the Provider in this case operates on a September 30 fiscal year.

The evidence at the hearing indicated that the Intermediary issued a number of bulletins advising all providers of the need to update their data annually in order to continue to receive pass-through treatment. Further review of the evidence and testimony revealed that a significant number of providers serviced by the fiscal intermediary all made proper elections to receive CRNA costs. Thus, the Board finds there was not a communication problem between the Intermediary and the Provider. Additionally, the Board notes that the Provider=s consultant was aware of the statutory requirements.

The Board finds that the Provider=s interpretation of Intermediary Bulletin 92-08 is without merit. The Provider argues that no documentation or notification is required for the 1992 year in order to continue to receive pass-through payments. However, Intermediary Bulletin 92-08 clearly states: [[i]f you did not qualify in calendar year 1991 you are ineligible for this cost report reimbursement in calendar year 1992]. The facts and testimony indicate that the Provider qualified in 1990 but failed to file the requisite notice for 1991. The Board notes that there is no automatic carryover provision in the law from 1990 to 1991. Therefore, since the Provider did not qualify in 1991 the automatic qualification provision for 1992 per Intermediary Bulletin
92-08 is not applicable to the case at hand.

Based on the above, the Board finds that the Provider is not entitled to CRNA pass-through treatment for calendar years 1991 and 1992.

DECISION AND ORDER:

The Intermediary=s adjustments are affirmed as to 1991 and 1992. However, the Intermediary adjustment is modified to permit pass-through reimbursement of CRNA costs for the last three months of calendar year 1990.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman