PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D20

PROVIDER –
Parkview Memorial Hospital
Fort Wayne, Indiana

Provider Nos.: 15-0021

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
AdminaStar Federal

DATE OF HEARING –
March 30, 2004

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 02-1342

INDEX

ISSUES:

1. Whether for purposes of evaluating the Routine Cost Limit (RCL) exception request, the base year per diem amounts should be adjusted to reflect reclassifications made by the Provider.

2. Whether the Intermediary properly offset the costs for the "private room differential" from the direct cost centers only.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare payment to 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 or PRRB) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Parkview Memorial Hospital (PMH or Provider) is a short-term acute-care hospital located in Fort Wayne, Indiana. The Provider has a hospital based skilled nursing facility (SNF), known as Parkview Continuing Care Center (PCCC). PCCC is a sub-provider of PMH and its costs are included on PMH's Medicare cost report.

The Provider requested an exception of $84.95 per day to the Medicare RCLs on the basis of providing atypical services for the cost reporting period ended December 31, 1998. By letter dated January 5, 2001, the Intermediary approved an interim increase of $62.56 per "Program" day, thereby increasing the per diem allowance from $144.00 to $206.56.[1]

The Provider asked AdminaStar Federal (Intermediary) to reconsider the amount of the interim exception, but the Intermediary refused. The first NPR, issued on September 27, 2001, reimbursed the Provider $206.56 per day for the inpatient services rendered to its Medicare

[1] Intermediary Ex.2.

patients. This amount included the interim exception amount of $62.56 per day. The Provider filed an appeal with the PRRB on March 19, 2002. The Intermediary later reopened the NPR and issued a revised determination that increased the Provider's exception amount to $69.30. As a result of the increase in the exception amount included in the revised NPR, the variance between the exception amount requested and the amount approved now stands at $15.65 per day.

The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R. §§405.1835-1841. The total amount of controversy is approximately $137,000.

Charles MacKelvie, Esq. of The MacKelvie Law Firm represented the Provider. James R. Grimes, Esq., of the Blue Cross/Blue Shield Association represented the Intermediary.

ISSUE 1: BASE YEAR PER DIEM RECLASSIFICATIONS
BACKGROUND:

42 U.S.C. §1395x(v)(1)(A) of the Social Security Act authorizes the Secretary to establish limits on provider costs recognized as reasonable in determining Medicare program payment. 42 U.S.C. §1395yy(a) establishes the RCLs applicable to this appeal. The regulations at 42 C.F.R. §413.30(f)(1) (1998) permit providers to request from CMS an exception to its RCLs on the basis of providing atypical services.

Provider Reimbursement Manual (PRM) §2534 sets forth the Peer Group methodology in which a provider's costs are compared to its peer group. Section 2534.5 dictates that the per diems, which are ultimately compared to a provider's per diems, are calculated using base year (1992) amounts. The base year amounts are split between direct and indirect cost centers, and then each 1992 cost center (both direct and indirect) is assigned a percentage of total cost by dividing the base year amount for each per diem by the total base year per diem cost. Accordingly, §2534.5B states in pertinent part:

> Uniform National Peer Group Comparison.-- . . . If indirect costs are directly assigned (e.g. nursing administration (indirect cost) assigned to the direct cost center), the indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred. The ratios are then based on the averages for the cost centers reflecting the reassigned costs.

Moreover, §2534.10A continues in relevant part:

> Atypical Direct Cost.-- . . . In addition, direct costs may also include directly assigned indirect costs such as nursing administration and social services. See §2534.5.B for instructions concerning the assignment of costs for purposes of constructing the peer group. When a provider has directly assigned any indirect costs (e.g., social services), it is necessary for the provider to separately identify

the costs and for purposes of comparison to the peer group, compare this cost to the peer group amount.

To create the Peer Group for comparison to the Provider's FYE 1998 costs at issue, the 1992 percentages for each cost center were multiplied by the 1998 Peer Group RCL. The final product for comparison was the base year per diem amount updated (applying the percentages identified) to the total 1998 Peer Group RCL.

In its as filed cost report, the Provider directly assigned some of its indirect costs to its direct nursing cost center. In calculating the exception amount, both parties agree that the Provider properly reclassified indirect costs to the appropriate indirect cost center. However, the Provider also sought to reclassify the Peer Group's base year per diems by the same ratio as the Provider reclassified its own costs. Upon review, the Intermediary disallowed the Provider's reclassification of the peer group's base year per diems.

PROVIDER'S CONTENTIONS:

The Provider contends that the PRM dictates that the Peer Group's base year per diems should be reclassified. Also, removing the Provider's direct costs without making a corresponding Peer Group reclassification, disproportionately lowers the costs in the Provider's direct cost center compared to the corresponding Peer Group's direct costs. The Provider claims that other AdminaStar divisions, which are part of the same corporation as AdminaStar Federal - Indiana and operate under the Anthem Insurance Company banner, have allowed other Providers to adjust the Peer Group per diems. The Provider also distinguishes this case from the Board's decision in Fort Bend Community Hospital - SNF v. Mutual of Omaha Insurance Company, 2000-D86 (September 21, 2000), as the Provider in that case did not actually reclassify the Peer Group amounts.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that no authority permits the Provider to adjust the Peer Group per diems. Moreover, PRM §2534.5B explains that CMS performed the necessary reclassifications before publishing the Peer Group per diem. The Peer Group per diems are standard points of comparison, or averages, for all providers and should not be changed to reflect the classifications of individual providers. The provider-specific reclassification permitted under §2534.10 simply ensures that the indirect costs are in the proper cost centers before being compared to the Peer Group.

ISSUE 2- PRIVATE ROOM DIFFERENTIAL OFFSET:

The Provider appealed the Intermediary's calculation of the private room differential used for the Peer Group comparison, and the Intermediary did not dispute the Provider's arguments, making this issue moot. (Intermediary's post-hearing brief, page 2)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, and the parties' contentions and evidence submitted, finds and concludes the following:

BASE YEAR PER DIEM RECLASSIFICATIONS:

The Board finds that the Intermediary properly followed the instructions for reclassifying the Provider's costs pursuant to the PRM §§2534.5 and 2534.10. The Peer Group per diems are a standard point of comparison for all providers and cannot and should not be changed to reflect particular cost classifications of an individual provider. Moreover, the record contains insufficient evidence to establish that the Peer Groups were erroneously constructed. The Board notes that adopting the Provider's proposed methodology would be illogical in the sense that it assumes that all of the providers comprising the Peer Group contained the identical incorrect assignment of costs as the Provider in this case.

DECISION AND ORDER:

Issue 1: Base Year Per diem reclassification:

The Intermediary properly disallowed the reclassification of the base year per diems.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: January 7, 2005

Suzanne Cochran
Chairperson