PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D4

PROVIDER -
Flagstaff Medical Center
Flagstaff, Arizona

Provider No.: 03-0023

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
November 15, 2007

Cost Reporting Periods Ended –
June 30, 1997 through June 30, 2001

CASE NO. 04-1915

INDEX

ISSUE:

Whether the Intermediary properly calculated and applied the Provider's ambulance cost per trip limit.

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. §1395h, 42 C.F.R. §§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 reasonable cost 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 but 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.

42 U.S.C. §1395x(v)(1)(A) also authorizes the Secretary of DHHS to establish limits on allowable costs incurred by providers of health care services. The limits may be based on estimates of costs found necessary in the efficient delivery of health care services.[1] Relevant to this case is section 4531 of the Balanced Budget Act of 1997 (BBA), which established a national fee schedule for ambulance services furnished on or after January 1, 2001.[2] Prior to implementation of the fee schedule, the BBA limits reimbursement for ambulance services as follows:

[1] 42 C.F.R. §413.30ff implement the cost limit provisions of 42 U.S.C. §1395x(v)(1)(A).
[2] See Intermediary Exhibit I-9.

> (a) Interim Reductions—(1) Payments determined on reasonable cost basis.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4451, is amended by adding at the end the following new subparagraph: (U) In determining the reasonable costs 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. . . 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.
>
> 1997 Balanced Budget Act, Chapter 3, §4531(a)(1)(U), See Provider Exhibit 6.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Flagstaff Medical Center (Provider) is an acute care hospital located in Flagstaff, Arizona. During its cost reporting periods ended June 30, 1998 through June 30, 2001, the Provider furnished both ground and air ambulance services to Medicare beneficiaries. Blue Cross and Blue Shield of Arizona (Intermediary)[3] reviewed the Provider's cost reports and applied the interim cost limits of section 4531 of the BBA to the Provider's ambulance costs. In doing so, the Intermediary applied a single limit to both the Provider's ground and air ambulance costs. In addition, based upon its interpretation of the BBA, the Intermediary determined the Provider's per trip limit for each affected cost reporting period based on the costs the Provider incurred in each of the immediately preceding cost reporting periods. The Intermediary also applied the limit to the Provider's ambulance costs incurred after January 1, 2000, because CMS was unable to implement the required fee schedule payment methodology until April 1, 2002.[4]

The Provider appealed the Intermediary's calculation and application of the interim ambulance cost limits 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 $916, 320.[5]

The Provider was represented by Gregory Kuzma, Chief Financial Officer, Flagstaff Medical Center. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

---

[3] Noridian Administrative Services subsequently replaced Blue Cross and Blue Shield of Arizona as the Provider's Intermediary.
[4] Transcript (Tr.) at 35.
[5] Provider Position Paper at DISCUSSION OF ISSUES.

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary, pursuant to the BBA and program instructions issued by CMS in Program Memorandum A-98-2,[6] calculated a per trip limit for its ambulance costs from its 1997 base year cost report. However, the Intermediary never notified the Provider of this limit, as instructed by CMS, denying the Provider its right to appeal the Intermediary "final determination."

Moreover, a single limit applicable to both air ambulance costs and ground ambulance costs should not be used. Owing to the large disparity in the nature of these services and their respective costs, the Intermediary should have developed a separate limit for each of these services.

The Provider also argues that the intention of the BBA is to have an ambulance limit (albeit, one for air services and one for ground services) established from a provider's 1997 base year, and for that limit to be updated each year for inflation and applied to subsequent cost reporting periods. The Provider asserts that the Intermediary misinterpreted the BBA by establishing a new limit for each cost reporting period based on the year immediately preceding an effected cost reporting period.

Finally, the Provider contends that CMS does not have the authority to apply the per trip limits imposed by the BBA after January 1, 2000,[7] even though the ambulance fee schedule reimbursement methodology was not implemented on time.

The Intermediary acknowledges that the Provider was not notified of the initial ambulance per trip limit, but argues that the Provider was not prejudiced by failure to provide that notice. The limit was developed from a finalized cost report and the Provider could have appealed any adjustments made to its ambulance costs.[8]

The Intermediary does agree that applying a single per trip limit to both air and ground ambulance services may result in some underpayments and overpayments. However, CMS addressed this matter in a Questions and Answers issuance dated April 23, 1999. Essentially, CMS acknowledged the potential for some providers to be disadvantaged by the single rate, but also stated that the single rate was only an interim measure until the fee schedule was implemented.[9]

The Intermediary disagrees with the Provider's argument that a single limit is to be developed from a 1997 base period, and updated thereafter in order to be applied to each subsequent cost reporting period. Rather, the Intermediary interprets the BBA as requiring a per trip limit to be determined based upon the costs incurred by a provider in the immediately preceding cost reporting period. The Intermediary refers to an

---

[6] Exhibit P-6.
[7] Provider's Position Paper at B. Argument. Tr. at 22.
[8] Tr. at 29.
[9] Exhibit I-6 at Question 11.

Administrative Bulletin issued by the Blue Cross Blue Shield Association on May 11, 1999, supporting this position.[10]

And finally, the Intermediary contends that it has the authority to apply the per trip limits of the BBA to ambulance costs incurred after January 1, 2000.[11] The Intermediary cites the CMS Administrator's decision affirming this position in Decatur County General Hospital v. Blue Cross Blue Shield Association/Riverbend Government Benefits Administrators, PRRB Dec. No. 2007-D28, April 20, 2007, modif'd, CMS Admin., June 27, 2007 (Decatur).[12]

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 as follows:

The Intermediary should have notified the Provider of its 1997 per trip limit as directed by CMS in Program Memorandum A-98-2.[13] However, there is no evidence that such notification would have resulted in a different outcome. Through the instant appeal the Provider has successfully challenged the Intermediary's calculation and application of the per trip limits of the BBA. Testimony elicited at the hearing shows the Provider was not prejudiced by its failure to receive notice of the initial limit determined by the Intermediary.[14]

The Intermediary correctly determined the Provider's per trip limits based upon the costs incurred by the Provider in the fiscal year immediately preceding each cost reporting period, e.g., the limit determined from the Provider's 1997 cost report is updated for inflation and applied to the Provider's 1998 costs, and a limit determined from the Provider's 1998 cost report is updated for inflation and applied to the Provider's 1999 costs, and so on.[15] Notably, the language of subparagraph U of the BBA is not entirely clear and can be read to support the Intermediary's application as well as the Provider's interpretation of that statute. That is, subparagraph U can be read to mean that a limit is to be determined from a provider's 1997 fiscal year's costs and that once that limit is established it is then updated each year in order to be applied to the subsequent cost reporting periods.

It is undisputed that more accurate program payments would result if there were separate per trip limits for air ambulance costs and ground ambulance costs as opposed to a single

[10] Intermediary's Revised Final Position Paper, Exhibit I-5 at Question 3.
[11] Intermediary's Revised Final Position Paper at 6.
[12] Exhibit I-10.
[13] Exhibit P-6.
[14] Tr. at 29 and 46-47.
[15] Apparently due to oversight, the Intermediary incorrectly calculated and applied a per trip ambulance cost limit derived from the Provider's 1997 cost report to the review and final settlement of the Provider's 1999 cost report (see Intermediary's Revised Final Position Paper at 2, Point B, and Tr. at 35-39). This final settlement must be revised by applying a per trip ambulance cost limit determined from the Provider's 1998 cost report to the Provider's 1999 costs.

limit applicable to each of these services combined. Moreover, it is undisputed that using a single limit likely resulted in some providers being overpaid while others were underpaid. However, there is no language in the statute addressing this matter or indicating in any way that separate limits must be used to distinguish air ambulance service costs from ground ambulance costs. The Secretary also found no provision in the law that mandated this distinction be made and explained its rationale for using a single limit in a Question and Answers issuance dated April 23, 1999,[16] and in the preamble to the pertinent regulation. 67 Fed. Reg. 9117 (Feb. 2002). Based upon these facts, the Board finds the Secretary's interpretation of the statute reasonable and defers to the Secretary's decision to use a single limit applicable to both air and ground ambulance costs during interim period beginning on October 1, 1997 and ending prior to January 1, 2000.

Finally, the Board finds as it did in Decatur. No statutory or regulatory provision extended the cost per trip limits beyond January 1, 2000. 42 U.S.C. §1395x(v)(1)(U), which establishes the cost per trip limit, states:

> [i]n determining the reasonable costs 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, . . .

Accordingly, for all cost reporting periods, or portions of cost reporting periods on or after January 1, 2000, and before April 1, 2002, the Provider is entitled to be paid for ambulance services provided to Medicare beneficiaries on the basis of Medicare's principles of reasonable cost reimbursement.

DECISION AND ORDER:

The Intermediary properly determined a single per trip ambulance cost limit applicable to both air ambulance service costs and ground ambulance service costs combined.

With the exception of the Provider's fiscal year 1999 cost report, the Intermediary properly applied a per trip ambulance cost limit determined from the Provider's costs in the immediately preceding cost report. The Intermediary must revise the Provider's fiscal year1999 cost report to apply a per trip limit determined from the Provider's fiscal year 1998 costs.

The Intermediary improperly applied a per trip ambulance cost limit to Provider costs incurred on or after January 1, 2000. The Intermediary's application of these limits is reversed.

---

[16] Intermediary's Revised Final Position Paper at 6. Exhibit I-6.

Board Members Participating:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: December 18, 2008