PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D26

PROVIDER –
Aroostook Medical Center
Presque Isle, Maine

Provider No. 20-0018

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/Associated Hospital Service of Maine

DATE OF HEARING -
March 17, 2003

ESRD Closing Window
August 30, 2000

CASE NO. 01-0883

INDEX

ISSUE:

Was CMS' denial of the end stage renal disease composite rate exception request correct based on applicable Medicare law?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Aroostook Medical Center (Provider) is a general acute care hospital which provides end stage renal dialysis (ESRD) services and is located in Presque Isle, Maine. This case concerns the Centers for Medicare and Medicaid Services' (CMS)[1] denial of the Provider's application for relief from the composite payment rate established for its Medicare-certified renal dialysis facility. Pursuant to the provisions of § 1881(b)[2] of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq., ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system. Under this system, a provider of dialysis services receives a prospectively determined payment for each dialysis treatment that it furnishes. An ESRD facility must accept the composite prospective payment rate established by CMS as payment in full for covered outpatient dialysis. During certain periods of time referred to as "exception windows," an ESRD provider may request an exception to its composite rate in accordance with the procedures established under 42 C.F.R. §413.180. Such an exception window was opened by HCFA commencing on March 1, 2000. The Provider filed an exception request based on its claim that it met the exception criteria as an "isolated essential facility."

The Intermediary reviewed the Provider's request, concluded that the Provider was "isolated," "essential," and that its cost per treatment was reasonable and related to the isolated essential facility criteria.[3] Accordingly, the Intermediary recommended a composite rate of $218.97, or an increase of $96.35 per treatment.[4]

CMS did not follow the Intermediary's recommendation, concluding that the Provider failed to justify its costs and relate them to the isolated essential facility criteria. CMS denied any adjustment to the Provider's composite rate.[5] The Provider filed a timely request for a hearing before the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

It was undisputed that, at the time of the exception request, the Provider served forty two patients in Aroostook County, Maine. Arookstook County, the northernmost county in Maine, is an expansive but sparsely populated rural area. It is located approximately 160 miles from the next nearest dialysis facility in Bangor, Maine. At the hearing, the parties stipulated that the Provider met the "isolated" prong of the exception criteria. The issues before the Board are whether the Provider also met the "essential" prong of the criteria

[1] Previously called Health Care Financing Administration (HCFA).
[2] 42 U.S.C. §2395rr.
[3] See Exhibit P-9
[4] Id.
[5] Id.

and, if so, whether the Provider met the requirements of the regulations and the Provider Reimbursement Manual (PRM) to demonstrate that its costs that exceeded the composite rate were "directly attributable" to the Provider's being isolated and essential. 42 C.F.R. §§413.180(f)(3) and 413.182.

The Provider was represented by William H. Stiles, Esquire, of Verrill and Dana, LLP. The Intermediary was represented by Eileen Bradley, Esquire, of Blue Cross Blue Shield Association.

The Regulations:

The regulations establish that for a provider to be granted an exception to the payment rate, it must demonstrate that its costs in excess of the payment rate are "specifically attributable" or "directly attributable" to the criteria under which it seeks to qualify, in this case, "isolated" and "essential." 42 C.F.R. 413.180(f)(3) and 413.182. Section 413.180(f) addresses the documentation required generally for an exception request: Section 413.186 details the documentation needed to qualify under the isolated essential facility criteria.

The crux of this case is whether the Provider furnished the documentation required by the regulation in its request to CMS, for the regulations further provide that:

> The facility may not submit to the . . . PRRB, any additional information or cost data that had not been submitted to [CMS] at the time [CMS] evaluated the exception request.

42 C.F.R. 413.194(c)(2).

The Parties' Positions:

The Intermediary[6] asserts that CMS's determination was justified because the Provider's application failed to meet both the general documentation requirements set forth at 42 C.F.R. §413.180 and the specific regulatory standards for exception requests filed under the isolated essential facility criteria at 42 C.F.R. §413.186. The application deficiencies were not marginal but went to the very issue of whether the Provider could qualify as an isolated essential facility. Faced with a deficient application, CMS had no choice under 42 C.F.R. §413.180(g) but to deny the Provider's request.

For example, the Intermediary points out that the Provider failed to submit its most recent cost report. Section 413.180(f) states, in relevant part:

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[6] Although it is CMS's decision that is appealed, CMS is not a party to the hearing; the Intermediary is the proper party even though it may have made a recommendation that is contrary to HCFA's ultimate determination. 42 C.F.R. §405.1843.

> If the facility is requesting an exception to its payment rate, it must submit to HCFA it most recently completed cost report . . .

Section 413.186(c)(4)(iv) also requires, among other documentation, that the provider submit "[a] copy of the latest filed cost report . . ."

The Intermediary also points out that the regulations require that the provider submit "[a] list of patients by modality showing commuting distance and time to the current and the next nearest renal dialysis facility." 42 C.F.R. §413.186(c)(4)(vi). Although the Provider had detailed the distance between a patient's residence and the Provider, it did not include the distance from the residences to the next nearest alternate dialysis facility and thus failed to address a critical element required to provide that the facility is "essential."

The Provider does not dispute that it failed to submit its cost report with its request but argues that it did submit those cost report pages that specifically pertain to the ESRD facility. The Provider argues that such a technical requirement elevates form over substance and fails to address in a meaningful way the purpose of the cost reporting information in the first place. The Provider believes the cost report is required so the Intermediary can make a determination that the Provider's costs are reasonable. In this case, the Provider supplied the "I-series," the cost report worksheets that accumulate and report the costs related to the dialysis unit.

With regard to the patient travel time and cost requirements, the Provider responds that CMS misapplied the applicable law and disregarded information contained within the request. It points out that, unlike other types of ESRD exception requests which require the submission of additional documentation and information, an isolated essential facility "only needs to submit the documentation listed in subsection E," citing HCFA Pub. 15-1 §2725D (emphasis added.) This more limited documentation requirement is intended to "provide an explanation of how the facility's cost per treatment in excess of its composite rate is related to the isolated essential facility exception criteria." Id. The Provider insists that its request demonstrated that its cost per treatment was reasonable, and that the costs in excess of its composite rate were justifiable and attributable to its isolated essential status.

The Provider further alleges that CMS's testimony in this case makes clear that the criteria are too subjective and that no amount of documentation would have satisfied CMS. It believes the text of the denial provided hints that CMS was purposefully looking for a reason to deny the request. In addition to it claim that CMS imposed documentation requirements that it knew or should have known were not required by the PRM, the Provider characterizes CMS' witness testimony as going to great lengths to fabricate confusion by misinterpreting the Provider's documentation, disregarding matters within CMS's knowledge and dispensing with common sense.

The Provider is requesting a per treatment exception to its ESRD composite rate in the amount of $78.92, as[7] follows:

Staffing Costs ($50,295)	$ 8.46
Delivery ($35x2x52x4.5%/5940)	.64
Medical Director ($16,800/5940)	2.83
Dialyzers ($18 each use)	18.00
Software ($17,300)	2.91
Nursing local non-availability costs ($10,635)	1.80
Volume/Overhead/Economies of Scale	44.28
Total	$ 78.92

The calculation is based upon FY 2001 projected treatments (5,940) and projected costs,[8] excluding drug costs.

The Provider's exception request for staffing costs was based on an assumption that it would introduce a third shift. CMS found the staffing ratio to be unreasonable. The Intermediary point outs that the provider's materials provide no analysis or documentation addressing the potential of adding several additional machines to the existing complement in order to maintain the same staffing on the existing shifts. This issue also impacts the Provider's claim for a rate increase for dialyzers, one of the largest components of the request.

CMS criticized as being cost inefficient and ineffective the facility's management decision to use one-time dialyzers in the face of an industry practice that overwhelmingly reuses dialyers. CMS noted that the Provider supplied no information to support the difference in cost between using one-time dialyzers and the staff cost incurred to clean and prepare the dialyzers for reuse despite a high level of non-productive time identified for the technicians on the third shift. CMS concluded that devoting those resources to cleaning and sanitizing the dialyzers for reuse, a common practice in the industry, would certainly be a more effective and efficient use of dollars than paying the staff for down time.

The Provider attacks CMS's assertion that "85% of rural facilities reuse dialyzers"[9] as not being supported by documentation and because there was no proof that the rural facilities referred to were isolated and essential. The Provider also points out that while CMS suggests that the Provider's explanation regarding reusing dialyers was insufficient, CMS was nevertheless able to arrive at an alternate calculation of the excess cost ($59,963).

With regard to the Provider's claim for delivery charges, CMS concluded that the supply costs attributed to Affiliated Materials were overstated because a $60 per month surcharge "for putting together the supplies ordered from Affiliated Materials" would be

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[7] The Provider reduced its claim for an increase before the hearing.
[8] See Exhibit P-6(10).
[9] See Exhibit P-1.

disallowed for Medicare purposes. In addition, the Corporate Express fuel surcharge was incorrectly based upon the Affiliated Materials invoice rather than the Corporate Express invoice. This caused the Provider's non-allowable supply delivery costs to be overstated by $12,150.

The Provider responds that CMS went to great lengths to find a problem with the Provider's delivery surcharges, even though it conceded that the Provider was required to pay them.[10]

The Provider's claim for excess costs related to the $1400 a month for the medical director's travel was rejected as being unsupported by documentation. The Provider cites this denial as an example CMS's unfairly characterizing some of the Provider's documentation as "confusing" or insufficient by focusing on what the Provider regards as irrelevant or improper inquiries. The Provider asserts that CMS assumed that the $1,400 per month traveling allowance for the medical director was limited to mileage. But CMS's witness conceded at the hearing that even government employees are entitled to be reimbursed for mileage, airfare, hotel cost and meals during travel, in addition to their usual hourly wage or salary. However, for the purposes of reviewing the request, CMS did not consider anything more than their mileage. The Intermediary responds that the Provider failed to submit documentation to show what the travel costs were.

CMS found that software costs to permit online physician monitoring of patients from Eastern Maine Medical Center should not be allowed in full because the Provider failed to relate the costs to a lack of on-site physicians. The Provider responds that CMS's rationale "rings hollow" in that CMS clearly understands the difficulty of attracting a full time medical director to an isolated area with a low volume of patients.

Similarly, CMS found the Provider's claim for $10,635 for "nursing coverage due to local nonavailability" to be unsupported because there was "no other explanation or analysis for those costs."[11] The Provider responds that CMS certainly understood and should have applied its knowledge that one of challenges faced by isolated essential facilities was the difficulty of maintaining a sufficient nursing pool, and that, from time to time, a facility must pay a premium to provide temporary coverage when local nurse coverage is not available.

The Provider complains that CMS professed ignorance regarding the provider's volume, overhead and economies of scale argument,[12] referring to the Providers' arguments as "fluff statements,"[13] despite low volume and an inability to achieve economies of scale being the exact reasons Congress and CMS originally created an exception for isolated essential facilities. 42 U.S.C. §1395rr(b)(7) (requiring exception for isolated rural facilities); 48 Fed. Reg. 21254, v. May 11, 1983 (explaining that isolated essential facility exception was designed to ensure access to care). Moreover, the regulations and

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10 See Exhibit P-1.
11 Exhibit P-1, p2
12 Exhibit P-1; Tr. at 366-368
13 Tr. at 366-367.

PRM specify low volume as a factor that contributes to higher per treatment costs for isolated essential facilities. 42 C.F.R. §413.186(b)(3); HCFA Pub. 15-1 §2725.3.D. The Provider insists it did exactly what PRM Section 2725.3D required: It provided a computation of its utilization and explained how fluctuations in patient volume affected its cost per treatment. Due to its location, it could not generate a sufficient volume of treatments to cover the cost of providing an essential service.[14] The Provider points out that, either the CMS denial letter nor CMS's witness found that the Provider's costs were not reasonable.

The Intermediary's responds that the figures offered by the Provider in support of its "economies of scale" costs are clearly a "plug number" designed to make the composite rate plus "additional costs" equal the Provider's projected costs for 2001. The Provider identified it as an expandable catch-all to the extent that, as some of the other numbers decrease, this figure would expand.[15]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and Program Instructions, evidence presented and the parties' contentions,[16] finds and concludes that CMS properly denied the Provider's request for an exception to the end-stage renal dialysis composite rate.

The regulation at 42 C.F.R. §413.186(c)(4) provides a list of items that must be furnished in a format that concisely explains the Provider's cost and patient data supporting the request. These include a copy of the latest filed Medicare cost report or budgeted cost report (subsection iv), and a list of patients by modality showing distance and time to the current and the next nearest renal dialysis facility (Subsection vii). Contrary to the Provider's argument that HCFA Pub. 15-1 §2725.3.E suspends these requirements, it specifically lists these documents as among those required. It is undisputed that the Provider did not submit its full cost report, nor did it provide a listing of patients and time and mileage from their residences to the next nearest facility.[17] The Provider, therefore, failed to meet two of the objective requirements of the regulations.

The Board finds that the Provider also failed to document that costs in excess of the composite rate related to the essential facility criteria.[18] The largest component of the request, Volume/ Overhead/ Economies of Scale appears to have been a catch-all category which the Provider rationalized as simply resulting from its isolated essential situation. This argument is circular. The essence of the regulatory requirement is to show how costs were incremental due to the isolated status. Regarding the other major component of the exception request, one-time use dialyzers, the Board finds that the use of these dialyzers was a management decision. There was no evidence presented to even

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[14] Exhibit P-6, p.4, 5, 6 and 8.
[15] Tr. at 261.
[16] The Board did not rely on the content of the Intermediary's post-hearing brief. It was submitted after the Board's due date determined at the conclusion of the live hearing.
[17] See Exhibit 6-Subsections 7 and 9.
[18] The isolated criteria of the regulation at 42 C.F.R. §413.186 is not in dispute. Both parties have stipulated to this point.

suggest that the decision not to reuse dialyzers was in any way related to the Provider's isolated or essential status.

Finally, 42 C.F.R. §413.194 prohibits the Board from considering additional information that had not been submitted to CMS at the time CMS evaluated the exception request. The Provider provided such information at the hearing, but the Board did not use it in making its decision.

Based on the above analyses, the Board concludes that CMS acted properly in denying the Provider's exception request.

DECISION AND ORDER:

CMS properly denied the Provider's exception request.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

DATE: June 9, 2004

FOR THE BOARD:

Suzanne Cochran
Chairman