PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D31

PROVIDER -
Roy L. Schneider Hospital
St. Thomas, Virgin Island

Provider No.: 48-0001

vs.

INTERMEDIARY -
Cooperativa de Seguros de Vida
de Puerto Rico

DATEs OF ESRD HEARINGs -
May 28, 2003
January 15, 2004

ESRD Window Closing -
August 28, 2000

CASE NO.: 01-1679

INDEX

ISSUE:

Whether CMS' determination to deny a request for an exception to the end stage renal disease (ESRD) composite rate based on a lack of documentation supporting the criteria of the isolated essential facility (IEF) was proper.

STATEMENT OF THE CASE STATUTORY, REGULATORY AND POLICY BACKGROUND:

Roy L. Schneider Hospital (Provider) is the only hospital facility and dialysis unit located on the island of St. Thomas in the United States Virgin Islands. The hospital's dialysis unit provides 78 patients with hemodialysis services. This dispute concerns the Centers for Medicare and Medicaid Services' (CMS) denial of the Provider's application for relief from the composite rate established for its Medicare-certified renal dialysis facility.

The Medicare program was established to provide health insurance to the aged and disabled. Hospitals that furnish services to Medicare patients are reimbursed under Title XVIII of the Social Security Act. See, 42 U.S.C. §1395 et seq. 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 the Medicare law, regulations and interpretative guides published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§412.20(b) and 413.24(b).

STATUTORY FRAMEWORK:

Pursuant to 42 U.S.C. §1395rr(b)(2) and (b)(7), Medicare benefits are provided to individuals who have been determined to have end stage renal disease (ESRD). Medicare payments are made to providers of services and renal dialysis facilities for the cost of renal dialysis for both institutional and self-dialysis care. A facility that furnishes dialysis services to Medicare patients with ESRD is paid a prospectively determined rate for each dialysis treatment furnished. This rate is a composite that includes all costs associated with furnishing dialysis services except for the costs of physician services and certain laboratory tests and drugs that are billed separately. The composite rate may be adjusted periodically to reflect actual facility costs. See also, 62 Fed. Reg. 43657 (August 15, 1997).

When a facility's costs are higher than the prospectively determined rate, CMS may, under certain conditions, grant the facility an exception to the composite rate and set a higher prospective rate. The periods of time during which CMS will consider a facility's request for an exception to the composite rate are generally referred to as "ESRD windows." A provider seeking an exception must show, on the basis of projected cost and utilization trends, that it will have a cost per treatment higher than its prospective payment rate and that the excess costs are attributable to one or more specific circumstances. 42 C.F.R. §413.180(b). These conditions are specified in the regulations at 42 C.F.R. §413.180 et seq. and the Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) §2720 et seq. Id.

Section 222 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999[1] amended 42 U.S.C. §1395rr(b)(7) and required that the ESRD composite rate be increased by 1.2 percent for treatments furnished on or after January 1, 2000. As a result, the composite rate ceiling found in the Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) §2705 increased from $130.00 to $147.67. See, Program Memorandum (PM) A-99-59 (December 1999). Further, HCFA announced the opening of a new exception window through PM A-99-59 based on the criteria set forth in 42 C.F.R. §413.180. Providers seeking an exception to the newly established composite rate had 180 days from March 1, 2000 (i.e., until August 28, 2000) to submit a valid exception request. Intermediaries were instructed to notify providers of their new composite rates and the opening of the exception window at least 30 days prior to March 1, 2000.

The Provider in this case requested an exception as an IEF during the window closing August 28, 2000. The parties agree that the Provider is an isolated and essential facility (Tr. at 345-347). The sole question at issue is whether the Provider furnished sufficient information to establish that it met the documentation requirements for an ESRD exception found at 42 C.F.R. §§413.180(f) and 413.186 and PRM §§2720-2722 and §2735.3.

Isolated Essential Facility

To qualify for an exception to the prospective payment rate based on being an isolated essential facility, the regulation, 42 C.F.R. §413.186(c)(3), requires the facility to document that (i) its cost per treatment is reasonable; and (ii) the facility's cost per treatment in excess of its composite rate relates to the isolated essential facility criteria specified in paragraph (b) of this section.

The facility must also furnish the following information in a format that concisely explains the facility's cost and patient data to support its request:

> (1) a list of the current and requested payment rates for each modality;
>
> (2) an explanation of how the facility's costs in excess of its composite rate payment are attributable to its being an isolated essential facility;
>
> (3) an explanation of any unusual geographic conditions in the area surrounding the facility;

[1] Sec. 222. Update in Renal Dialysis Composite Rate. (a) In General: Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new flush sentence:

> "The Secretary shall increase the amount of each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 1999, and for such services furnished on or after January 1, 2001, by 1.2 percent above such composite rate payment amounts for such services furnished on December 31, 2000".

(4) a copy of the latest filed cost report and a budget estimate for the next 12 months prepared on cost report forms;

(5) an explanation of unusual costs reported on the facility's actual or budgeted cost reports and any significant changes in budgeted costs and data compared to actual costs and data reported on the latest filed cost report;

(6) the name, location of, and distance to the nearest renal dialysis facility;

(7) a list of patients by modality showing commuting distance and time to the current and the next nearest renal dialysis facility;

(8) the historical and projected patient-to-staff ratios and number of machines used for maintenance dialysis treatments;

(9) a computation showing the facility's treatment capacity, arrived at by taking the total stations multiplied by the number of hours of operation for the year divided by the average length of a dialysis treatment; and

(10) the geographical boundaries and population size of the facility's service area.

42 C.F.R. §413.186(c)(4).

42 C.F.R. §413.180(f) requires that each provider requesting an exception must:

(1) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(2) Show that the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;

(3) Show that the elements of excessive cost are specifically attributable to one or more conditions specified in §413.182;

(4) Specify the amount of additional payment per treatment the facility believes is required for it to recover its justifiable excess costs; and

(5) Specify that the facility has compared its most recently completed cost report with cost reports from (at least 2) prior years. The facility must explain any material statistical data or cost changes, or both, and include an explanation with the documentation supporting the exception request.

In addition, PRM §2721 requires that providers document specific cost categories that CMS believes have a significant impact on costs. These include personnel (salaries, number of personnel, amount of time in dialysis unit, staff to patient ratios), staffing patterns, overhead, routine laboratory tests, drugs and medicines covered under the composite rate, supplies, routine and non-routine ancillary costs, physician reimbursement, machine depreciation and apportionment of inpatient and outpatient costs. Providers must state the current and requested payment rates, as well as the cost per treatment among other things.

PROCEDURAL BACKGROUND:

The Intermediary received the Provider's request for an exception as an IEF on July 11, 2000. The exception request was denied and returned to the Provider on August 3, 2000. The Provider resubmitted the exception request to the Intermediary on August 23, 2000 and the Intermediary forwarded it to CMS without a recommendation to grant or deny it. During the hearing the Intermediary explained that no recommendation was made because of pending litigation involving the exception request reviewer (a former Intermediary employee and now their consultant) and one of the Provider's key personnel who prepared the exception request.[2] CMS denied the Provider's request for an exception on October 26, 2000, finding that the Provider had not furnished documentation to demonstrate that it met the criteria to establish that it qualified as an IEF and was not, therefore, entitled to an exception in the amount of $58.83.[3]

CMS noted that the Provider was the only certified ESRD facility on St. Thomas, and the closest alternative facility was located in St. Croix, Virgin Islands. However, CMS could not determine that the Provider had met the requirements to qualify for an exception to the composite rate as an IEF because it failed to relate its excess costs to the IEF criteria. Specifically, CMS found that the Provider failed:

- to explain how the facility's cost per treatment in excess of the composite rate related to the [IEF] criteria specified in 42 C.F.R. §413.186(b), and

- to provide the 10 categories of information regarding the facility's cost and patient data as required by 42 C.F.R. §413.186(c)(4).

[2] Testimony of Alba Cosme, Tr. at 438-444.
[3] Provider's June 21, 2000 Exception Request

The Provider was represented by Daniel López Romo, Esq., the Intermediary was represented by Wallace Vázquez Sanabria, Esq., San Juan, Puerto Rico.

PARTIES' CONTENTIONS:

The Provider maintains that it complied with the requirements of the regulations regarding IEF exceptions by furnishing invoices for dialysis machines and chairs, staff positions and salaries. The cost of equipment and medical supplies was compared to the same items in Puerto Rico and California. The Provider furnished budget estimates based on an annualized projection because costs do not vary significantly on a month-to-month basis. The Provider did not believe the commuting distance to the nearest facility was relevant because there were no alternatives for the island residents.

The Intermediary contends that the Provider failed to identify the incremental costs and relate those costs to the isolated essential criteria of the regulation as required by 42 C.F.R. §413.186(c)(3). Further, the Intermediary observes the Provider did not furnish the information required in 42 C.F.R. §413.186(c)(4) regarding an explanation of the facility's costs and patient data to support its request for an exception to its ESRD composite rate.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law regulations, program instructions, parties' contentions and evidence, the Board finds that the Provider did not file a complete exception request. Consequently, the Board concludes that the Provider is not entitled to an ESRD exception as an isolated essential facility.

The regulations and manual provisions identify very specific information that a provider must include in an ESRD exception request. 42 C.F.R §413.186(c)(4), requires a provider to submit the following cost and patient data in support of its request. (See list of items required, infra.) The Board finds that the Provider failed to include this information in its exception request.

The Board notes that the Provider did furnish maps and travel information regarding other islands with dialysis facilities. However, this information was not included with the Provider's exception request, and the regulation precludes the Board from considering information or cost data that was not submitted to CMS at the time it evaluated the request. 42 C.F.R. § 413.194(c)(2).

Further, 42 C.F.R. §413.182(f) requires that providers requesting ESRD exceptions separately identify the elements of the cost contributing to cost per treatment in excess of the facility's payment rate and establish that the costs are related to being an IEF. The record contained a few invoices/purchase orders that documented the Provider's actual cost for a few items of equipment and supplies. However, there was no attempt to correlate that information to the amount of the variance between the composite rate and the allowance for equipment and supplies. In addition, the Provider's Chief Operating

Officer testified at length regarding the cost of traveling nurses being over $110, 000 per nurse,[4] but testimony indicated that no cost for these nurses was included in the computation of nursing costs.[5] Rather, the exception request included costs associated with permanent employee nurses and staff, and the cost of the permanent nursing staff was actually much lower than the composite rate.[6]

The Provider's exception request did not include documentation of facility costs, such as invoices, to support the higher cost of supplies,[7] air transportation and shipping costs[8] or electrical costs.[9] The Provider's testimony revealed that the Provider did not explain how those excess costs were directly attributable to being an IEF.[10] All of these elements are required for an IEF exception to be granted but were missing from the Provider's exception request.

DECISION AND ORDER:

CMS correctly denied the Provider's request for an exception to the ESRD composite rate in accordance with the regulatory provisions of 42 C.F.R. §§413.182 and 413.186. CMS' denial is affirmed.

Board Members Participating

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: April 8, 2005

Suzanne Cochran, Esq.
Chairman

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[4] Tr. at 354
[5] Id. at 466.
[6] Id. at 468-69
[7] Id. at 490
[8] Id. at 58-59
[9] Id. at 60
[10] Id. at 260