PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D45

PROVIDER -
UMass Memorial Medical Center
Worcester, Massachusetts

Provider No.: 22-0163

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Associated Hospital Service

DATE OF HEARING -
September 21, 2004

Exception Request Window Closing -
July 30, 2001

CASE NO.: 02-1213

INDEX

ISSUE:

Was the Centers for Medicare and Medicaid Services' (CMS) denial of the Provider's request for an exemption to the end stage renal disease (ESRD) composite rate proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

UMass Memorial Medical Center (Provider) is an acute care hospital located in Worcester, Massachusetts. The facility is the result of a merger between the UMass Medical Center and Memorial Hospital. The merger was effective April 1, 1998. However, each of the merging facilities was allowed to use its individual provider number through FYE 9/30/99. After that date, the combined facility used the single provider number originally assigned to UMass Medical Center. Both facilities had dialysis units which continued to operate separately after the merger. 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) 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 CMS commencing on March 1, 2000.

On July 2, 2001, the Provider filed a timely request for an atypical services exception to the implementation of the revised ESRD composite rates and sought an increase of $42.35 per treatment. Associated Hospital Services (Intermediary) reviewed the filing and recommended to CMS that the request be denied. CMS conducted its own review and concurred that the documentation submitted by the Provider was inadequate to support an exception to the ESRD composite rates. CMS completed its determination on September 20, 2001, and the Intermediary notified the Provider of CMS' denial on October 5, 2001.

The Provider filed a timely request for a hearing with the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841. The Provider was represented by Jeffrey A. Lovitky, Esquire. The

[1] Previously called Health Care Financing Administration (HCFA).

Intermediary was represented by Bernard M. Talbert, Esquire, of the 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, "atypical service intensity." 42 C.F.R. §413.180(f)(3) and §413.182. Section 413.180(f) addresses the documentation required generally for an exception request, while Section 413.184 details the documentation needed to qualify under the atypical patient mix criteria.

PARTIES' CONTENTIONS:

The Provider contends that its request merited approval based upon the higher acuity of patients treated. The Provider acknowledges that its application was incomplete at the time it was submitted. Nevertheless, the Provider also asserts that its application as filed amply demonstrated both higher than average patient acuity and increased cost resulting from its more acute patient population. Accordingly, the Provider maintains that it more than met the atypical service intensity criteria necessary to warrant approval of its exception request.

The Provider contends that the exception request must be deemed approved because CMS failed to timely deny the exception. This contention is based upon the plain language of 42 C.F.R. §413.180(h), which states "[a]n exception request is deemed approved unless it is disapproved within 60 working days after it is filed with its intermediary." The Provider asserts that the processing of an exception request does not end until the provider is notified. The Provider contends that because the Intermediary and CMS did not notify the Provider of CMS' decision to deny its exception request within 60 working days, it must be deemed approved.

The Intermediary counters that the CMS determination was correct, as the Provider's application failed to meet the general documentation requirements at 42 C.F.R. §413.180 and the specific standards for exception requests at 42 C.F.R. §413.184. The lack of documentation precluded CMS and the Intermediary from developing a full assessment on the merits of the application.

With regard to the requirement that the exception request be deemed approved unless the Secretary disapproves it by not later than 60-days after the date that the application is filed, the Intermediary argues that the legal measure for the denial is the date of the determination, not the communication of notice. The Intermediary argues that CMS' determination was timely made within the 60-day limit, although it did not communicate that decision to Provider within that time frame.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board finds that the Provider filed an incomplete exception request. The regulation at 42 C.F.R. §413.184(b) provides a list of items that must be submitted in a required format to document a request based upon atypical service intensity. The Board's examination indicated that a number of the items required were not included with the exception request. Items that were omitted included the listing of new patients, the list of transplants and patients waiting for transplants, the list of drugs used, cost report details, direct and indirect cost detail, cost per treatment information, supplies list, prudent buyer section, personnel information, physician fees and inpatient/outpatient charges. The Board noted that, while the regulation also requires that data supporting the exception request be for the most recent 12-month period, some data offered in support of the exception request was for the wrong cost reporting period or included activity for a 19-month period. Despite other contentions offered by the Provider, the information that was missing was absolutely required by the regulation. The Board has no authority to waive those requirements. The Board concludes that, where the regulation requires information and such information is omitted, the Provider has not met the requirements of the regulation and the omission is fatal to the application.

The Board also finds that the Provider's application was timely denied and may not be deemed approved under 42 C.F.R. §413.180(h). The Board acknowledges that the Provider's arguments were supported by prior PRRB decisions addressing similar circumstances. However, the Board's majority finds that the regulation does not require that notice be completed within the regulation's 60-day time limit. Rather, the regulation requires that a determination be made within that time. In this case, CMS made its denial determination within the time limit set by the statute and, consequently, the Provider's application cannot be deemed approved.

Based on the above analyses, the Board concludes that CMS acted properly in denying the Provider's request based on the lack of required documentation.

DECISION AND ORDER:

CMS properly denied the Provider's exception request.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq. (Concurring in part; dissenting in part)
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: June 14, 2005

Suzanne Cochran
Chairman

Separate Opinion of Suzanne Cochran, concurring in part and dissenting in part:

I concur with the majority's determination that the Provider's application was seriously deficient under the regulations and that the Board has no authority to waive those requirements. I disagree with the Board majority's determination that the regulatory deeming provisions at 42 CFR 413.180(h) do not require that notice be sent to the provider within the statutory time frame.

I do not dispute that the deeming regulation could be read literally as only requiring the CMS *decision* to be made within the 60-day period. Indeed, a literal reading would not even require that CMS' determination be made in writing within the 60-day time limit. But, that interpretation ignores the reality that notice is essential to the exception procedure and to fundamental notions of due process. Notice is not a mere formality; it triggers appeal rights and permits the Provider to reasonably budget or restructure to avoid future losses.

Congress imposed the deadline in the statute, thereby indicating its concern about CMS delays. Prior Board cases and the legislative history illustrate that Congress' concern was well founded.[1] Under the Board majority's decision, Congressional intent is frustrated if CMS fails to send notice of its decision. The 60-day limit is meaningless without communication. As the Board has noted in prior decisions,[2] the regulation has been interpreted as allowing CMS to strictly enforce time limits applicable to providers making an exception request.[3] It is only reasonable that the same strict enforcement principles apply to time limits for CMS found in the same regulation.

Had CMS promulgated a regulation that addressed time limits for the full process, including notice, and that established a regulatory grace period for transmission of the decision within a reasonable time after the decision was made, I believe it would pass muster as being consistent with the statute. But CMS chose instead to establish a cumbersome two-tiered notification system despite the 60-day limit and to describe the action required only as disapproval. Because the regulations are silent as to time limits for other steps in the process, I believe the statutory and regulatory time limit for disapproval must therefore be interpreted as including all essential elements of the disapproval process, including transmission of the notice. The notice was not sent until after the 60-day limit; therefore, I believe it must be deemed approved.

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1 See e.g. Mount Clemens General Hospital v. Blue Cross and Blue Shield Association/United Government Services, PRRB Dec. No 2002-D26, July 9, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,886, aff'd HCFA Adm. Dec. Sept. 6, 2002, Medicare & Medicaid Guide (CCH ¶ 80,943 and legislative history discussed at Providers Post Hearing Brief, pp. 18-19.

2 Id .

3 Children's Hospital of Buffalo v. Shalala, No 00-6187 (2d Cir. 2001), U.S. App. Lexis 979 (Jan. 24, 2001) (2001 Transfer Binder) Medicare & Medicaid Guide (CCH) ¶300,620.

Suzanne Cochran
Chairman