PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D26

PROVIDER -
Mary Hitchcock Memorial Hospital
Lebanon, New Hampshire

Provider No.: 30-0003

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Anthem Health Plans of New Hampshire, Inc.

DATE OF HEARING -
November 3, 2004

ESRD Window End Date -
December 31, 2001

CASE NO.: 02-0632

INDEX

ISSUE:

Whether the denial of the Provider's request for an exception to the renal dialysis composite rate by the Centers for Medicare and Medicaid Services (CMS) was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare payments due a provider of dialysis services for end stage renal disease (ESRD).

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 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).

ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system.[1] 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 unless it qualifies for one of the exceptions in accordance with the procedures established under 42 C.F.R. §413.180 et seq.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mary Hitchcock Memorial Hospital (Provider) is a tertiary care hospital located in Lebanon, New Hampshire. The Provider's hospital based outpatient renal dialysis unit provides outpatient hemodialysis services. The Provider also "backs up" freestanding dialysis units located in nearby communities and has a satellite unit located 82 miles away.[2] The Provider applied to Anthem Health Plans of New Hampshire (Intermediary) for an exception of $48.55 to the ESRD composite rate of $179.21 per treatment.[3] The regulatory basis for the Provider's request was atypical service intensity and the resulting additional nursing service and administrative costs.

[1] Section 1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq.,
[2] Provider Exhibit 14, "Atypical Indicators" at p.1.
[3] Provider Exhibit 14, "Amount Requested" at p.4.

By letter dated July 23, 2001, the Intermediary recommended denial of the exception request.[4] On August 31, 2001, the Intermediary notified the Provider that CMS had denied the exception request.[5]

The Provider then 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 Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

INTERMEDIARY CONTENTIONS:

In its denial, CMS stated that the Provider's patient characteristics do not clearly indicate that the Provider was treating an atypical patient mix. By submitting the fiscal year ended (FYE) 1999 cost report and patient data from its fiscal year (FY) 2000, the Provider did not properly match its patient data to its most recently completed cost report in accordance with 42 C.F.R. §413.184(b). Moreover, as the Provider failed to submit its FY 2000 cost report, it failed to provide an adequate explanation of material variances between its FY 2000 cost report and its budgeted costs for 2001 as Provider Reimbursement Manual (P.R.M.) §2721.F requires.

CMS also noted that, pursuant to 42 C.F.R. §413.180(f)(5), materials submitted to CMS must 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.

CMS also noted that the Provider failed to explain various discrepancies within the exception request regarding the total patient population count. The Provider failed to substantiate its additional staff minutes and should have used time studies to do so in accordance with P.R.M. §§2313 and 2725.1D.

The Intermediary also emphasized that the Board should not allow the Provider to expand or improve its allegedly flawed exception request in the course of the hearing.[6]

PROVIDER'S CONTENTIONS:

The Provider contends that it satisfied the atypical service intensity criteria contained in 42 C.F.R §413.184. Approximately 26 percent of the Provider's patients are over 75 years old, which is higher than the national rate of 14.5 percent. 12.4 percent of the

[4] Intermediary Exhibit 3.
[5] Intermediary Exhibits 4 and 5.
[6] Transcript (Tr.) at pp. 21-22.

Provider's patients are over 80 years old and 72 percent are 55 or older, which is higher than the national rate of 55.8 percent.[7]

Additionally, CMS' policy[8] to deny an Exception Request unless more than one indicia of atypicality exists and CMS's failure to consider patient referral patterns contradict the regulation at 42 C.F.R. §§413.184(a) and (b). The Provider, a nationally recognized academic medical center, is the only tertiary care academic center in New Hampshire. The Provider and its satellite are also isolated. The Provider furnished ample evidence that many of its patients initiated outpatient dialysis at the Provider's facility and once stabilized, transferred closer to home. This referral pattern supports the model of an academic medical center treating higher acuity patients, which accordingly satisfies the P.R.M. §2725.1 requirements.[9]

The Provider also claims that the national averages used by CMS are arbitrary and capricious, and the CMS witness was incorrect in his belief that a version of CMS Form 2728 is completed only by outpatients.[10] As CMS did not produce a copy of such form as requested,[11] and Form 2728 itself indicates that it must be completed by all patients, it is clear that the data in the ESRD Patient Profile is derived from both outpatients and inpatients. As the exception request process only applies to outpatient treatments, comparing a facility's outpatient population with national averages using all patients is invalid. Likewise, using average length of stay figures from 1994 as a basis for comparison to the Provider's average length of stay data for patients during 2000 is inappropriate, as the average length of stay has decreased over the years.[12]

Moreover, the alleged discrepancies that CMS relies upon in its denial have a logical explanation, as the Provider appropriately excluded certain patients from its counts for computing the transplant and mortality rates and age profile table. Moreover, using the higher patient counts would not materially impact the Provider's atypicality claim and would support a finding that the Provider's diabetic population is atypical.

CMS also erroneously required inclusion of FY 1999 patient data with the exception request, as the Provider fully complied with 42 C.F.R. §413.184(b) by providing patient data for FY 2000. Such regulation does not require patient data from the most recently submitted cost report year; it requires data from the most "recently completed fiscal or calendar year." Likewise, CMS erroneously denied the request on the basis that the Provider failed to submit the FY 2000 cost report with the exception request or perform a variance analysis between the 1999 and 2000 cost reports. The Provider failed to furnish the FY 2000 cost report as it had not yet been filed as of the Exception Request filing

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[7] See Exception Request (Provider Ex.14), Atypical Indicators Tab at p.3.
[8] Tr. at 198-200, 203-204, 213
[9] See Exception Request, Atypical Indicators Tab at pg. 6-7, and Attachments 10, 26 and 27.
[10] Tr. 195-198.
[11] Tr. 210-211
[12] Provider Exhibit 30

date due to CMS' extension of the cost report filing date for all providers.[13] Nevertheless, the Provider furnished the most recent variance comparisons possible based upon the data available through May 31, 2001.[14]

Additionally, the CMS reviewer misinterpreted P.R.M. §§2313 and 2725.1 as mandating the use of periodic time studies in calculating atypical staff minutes. Rather than using periodic time studies to estimate additional staff time, the Provider used a methodology which effectively documented the atypical staff time requested for each patient during the course of the entire year.[15]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, and the parties' contentions, concludes that CMS properly denied the Provider's exception to the ESRD composite payment rate.

The regulation at 42 C.F.R. §413.182 establishes that, to qualify for an exception to the prospective payment rate, a provider must demonstrate that its costs in excess of the payment rate are "directly attributable" to the criteria under which it seeks to qualify (in this case, "atypical service intensity (patient mix)"), and that its per-treatment costs are reasonable and allowable under cost reimbursement principles. Accordingly, the Provider is responsible for justifying and demonstrating to CMS' satisfaction that the requirements and criteria for an exception are met in full.

In order to qualify for an exception based on atypical service intensity, 42 C.F.R. §413.184(a)(1) dictates that:

> A facility must demonstrate that a substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients . . .

Additionally, 42 C.F.R. §413.180(f) generally addresses the documentation providers must submit with an exception request. That section states, in relevant part, that the materials submitted to CMS must

> . . . (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. (emphasis added.)

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[13] Provider Exhibit 16
[14] Exception Request at Attachments 14-18, Attachment 19 at pp. 19-43.
[15] Exception Request, Patient Categories Tab and Attachment 2, pp. 11-24.

Additionally, for providers seeking an exception based upon the atypical service intensity criteria, 42 C.F.R. §413.184(b) dictates that

> (1) A facility must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed fiscal or calendar year . . . (emphasis added.)[16]

The Board concludes that since the Provider's application contained fatal flaws, CMS properly determined that the Provider was not entitled to an exception. First, the Provider failed to provide a listing (with analysis) of all of its patients in accordance with 42 C.F.R. §413.184(b)(1). Besides the exception request's lack of clarity regarding the actual number of total patients claimed, the Provider implies it may not have included all of its satellites patients[17] and concedes that it failed to include home patients in its statistical comparisons and patient sampling.[18] Accordingly, although CMS recognizes that age is an indicator of patients who require more resources, the credibility of the Provider's claim that 55 percent of its treatments were rendered to patients over the age of 65[19] is undermined by the Provider's own admission that its calculations considered only a portion of the total patients.

The application is also flawed because the Provider failed to compare its most recently completed cost report with cost reports from at least two prior years in accordance with 42 C.F.R. §413.180(f)(5). The Provider only compared fiscal year 1998 to fiscal year 1999. The Board has no authority to waive this regulatory requirement.

Even if these fatal flaws were cured, the Board concludes that a reviewer could not verify the accuracy of the numbers due to conflicting data within the application. The application, on its face, was insufficient to establish that a substantial number of treatments were atypical. The Provider did not explain to the reviewer, nor did the

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[16] 42 C.F.R. §413.184(b) in its entirety, dictates that the listing must "show" patient characteristics in eleven specified categories. Additionally, with regard to satellites, P.R.M. §2721A specifies, in relevant part that "...when CMS processes an exception request from a hospital-based facility that has one or more satellite facilities associated with it, CMS reviews the costs and circumstances of the entire facility including all satellites to see if the exception criteria are met."

[17] Exception Request, Atypical Indicators Tab at p.1 ("We also have a satellite unit…Although we have enclosed some information on the North Country Unit, this request for an exception to the composite rate is only for our hospital based unit in Lebanon, New Hampshire..") (emphasis added.)

[18] Exception Request, Atypical Indicators Tab at p.1. ("Statistical comparisons in this document have been made between the entire chronic renal outpatient population of in-facility hemodialysis outpatients corresponding to our most recently complete fiscal year, FY 2000 and the national norm.") (emphasis added.)

[19] Exception Request, Atypical Indicators Tab at p. 4.

Provider's subsequent written explanation[20] or testimony clearly justify the discrepancies within the application.

The Board notes, however, that even if the Provider had submitted the information required under 42 C.F.R. §413.184(b)(1) and shown that it provided services of atypical intensity, the Provider was not entitled to an exception. The Provider did not demonstrate by convincing objective evidence that its per-treatment costs in excess of its payment rate were directly attributable to atypical service intensity in accordance with 42 C.F.R §413.182.

The Board recognizes that the parties disputed other factors regarding the adequacy and merits of the exception request; however, the Board concludes that additional analysis is unnecessary, as CMS properly denied the application for the reasons discussed above.

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. §§413.180-.184. CMS' denial is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.

FOR THE BOARD:

DATE: June 2, 2006

Suzanne Cochran, Esquire
Chairperson

[20] See Provider Final Position Paper at page 17.