PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D8

PROVIDER -
The Christ Hospital
Cincinnati, OH

Provider No. 36-0163

vs.

INTERMEDIARY -
Blue Cross and Blue Shield
Association/Adminastar Federal, Inc.

DATE OF HEARING-
October 7, 1999

Cost Reporting Period Ended -
July 5, 1994

CASE NO. 95-0527

INDEX

ISSUE:

Was the denial of Provider's End Stage Renal Disease (“ESRD”) composite rate exception request based on atypical service intensity/patient mix proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The issue in this appeal arises from the July 5, 1994 determination of the Health Care Financing Administration ("HCFA") that The Christ Hospital (“Provider”) is not entitled to an exception to its end stage renal disease ("ESRD") composite rate based on atypical service intensity/patient mix. In the interest of facilitating the “Hearing on Record” before the Provider Reimbursement Review Board (“Board”), the Provider and the Blue Cross and Blue Shield Association/Adminastar Federal, Inc. (“Intermediary”) entered into the following “Joint Stipulation”:

1. Provider is a tertiary care facility in the Greater Cincinnati, Ohio area and provides ESRD services to the community. Provider's ESRD services include inpatient and outpatient hemodialysis, inpatient and outpatient peritoneal dialysis, self-dialysis training and home support, and kidney transplantation. All of these services are provided for patients in Provider's service area and beyond.

2. On April 27, 1994, Provider submitted to the Intermediary its ESRD composite rate exception request based on atypical service intensity/patient mix and based on self-dialysis training. A copy of the exception request is contained at Provider's Exhibits I -A through 28.

3. Provider's exception request was transmitted to HCFA by letter dated May 5, 1994.

4. At the time the exception request was submitted, Provider's current composite rate was $131.33. The exception request sought a composite rate of $157.89.

5. By letter dated July 5, 1994, HCFA approved the rate exception request relating to self-dialysis training. That approval is not being challenged through this appeal, nor is it part of the case now before the Board.

6. In the same letter dated July 5, 1994, HCFA denied Provider's request for composite rate exception based on atypical service intensity/patient mix. A copy of HCFA's determination is included as Provider's Exhibit 29. In this appeal, Provider is only challenging the decision to deny the exception request relating to atypical service intensity/patient mix.

7. In 1993, Provider's ESRD services had a total patient population of 363 patients. As required for certain aspects of the applicable regulations and manual provisions, Provider divided its total patient population into three categories:

   Chronic maintenance hemodialysis 217 patients temporary patients 50 patients home dialysis 96 patients.

8. The sole basis for HCFA's denial of the exception request, as stated in its July 5, 1994 letter, was its belief that the Provider failed to sufficiently consider the home dialysis patients. Provider maintains that the home dialysis patients were sufficiently considered in its exception request.

9. This Joint Stipulation shall be considered part of the administrative record of the above-captioned appeal.

The Provider and the Intermediary agree that the only issue before the Board is whether HCFA's denial of the exception request was proper based on application of undisputed facts. Accordingly, the Provider appealed HCFA's determination that it is not entitled to an exception to its ESRD composite rate based on atypical service intensity/patient mix and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in dispute is $ 390,884. The Provider was represented by James F. Flynn, Esq. and Diane M. Signoracci, Esq. of Bricker and Eckler, LLP. The Intermediary's representative was Bernard M. Talbert, Esq. of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider's argument centers on its assertion that HCFA's denial decision made no findings or conclusions about the atypicality of Provider's service intensity and/or patient population.

The Provider contends that it submitted its exception request pursuant to 42 C.F.R. §413.170 and the Provider Reimbursement Manual, Part 1 ("HCFA Pub. 15-1") § 2720. For purposes of the exception request and in compliance with the spirit and letter of the applicable regulations and manual provisions,

the Provider notes that it divided its total patient population in 1993 of 363 patients into three categories:[1]

> (1) chronic maintenance hemodialysis patients (of which there were 217 in 1993);
>
> (2) temporary patients, described as those patients who are routinely dialyzed at other facilities but are transferred to Provider for stabilization and require more intense services than the other facilities are capable of providing (of which there were 50 in 1993); and
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> (3) home dialysis patients (of which there 96 in 1993).

The Provider points to an excerpt of HCFA's July 5, 1994 denial letter in which HCFA explained the basis for its determination to deny the request.[2] HCFA's letter states that:

> [b]ased on our review of the provider's documentation (pages 9-11) submitted to support the atypicality of its patient population, the Method I home patients (96) were omitted in computing any of the preceding patient averages. When comparing [Provider's] data with the Health Care Financing Administration's (HCFA) national data, the provider only used the total maintenance hemodialysis (267) and unidentified patients treated at [Provider]. It gave no consideration to the 96 home (CAPD and CCPD) dialysis patients. Method I home patients are paid under the composite payment rate and must be included in a patient comparison analysis.
>
> We did not recompute the percentages for the patient characteristics, i.e., diabetic, mortality, hypertensive, average length of stay, aged and other comorbidities, including Method I home patients, since it is not HCFA's responsibility to summarize the patient data to make them meaningful. According to section 2721 of the PRM, the facility is responsibility (sic) for justifying and demonstrating to HCFA's satisfaction that the requirements and the criteria are met. Therefore, we believe that [Provider] has not submitted evidential documentation to demonstrate that it has an atypical patient mix.

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[1] Provider Position Paper at 6; See also Provider Exhibit 1, pg. 1.

[2] Provider Exhibit 29; Intermediary Exhibit I-3.

HCFA Denial Letter of July 5, 1994, Exhibit I-3.

It is the Provider's position that if the above excerpt was HCFA's basis for the denial of the exception of the atypical patient mix, then presumably, HCFA found the rest of Provider's request to be acceptable. Thus, the Provider believes that HCFA's denial was based solely on its belief that the Provider did not consider home dialysis patients in the calculation of certain percentages contained at pages 9 to 11 of the narrative of Provider's exception request. See Provider Exhibit 1, pgs. 9-11.

The Provider contends that HCFA's review and decision on this exception request is inconsistent with the applicable regulation and manual provisions and is arbitrary. The Provider believes that its exception request carefully and completely responds to all of the criteria and considerations published. Further, the Provider asserts that the narrative and supporting documentation accurately portray its patient population and more than adequately substantiate an atypical service intensity/patient mix warranting adjustment to it's composite rate.

Therefore, the Provider contends that the only issue, then, is whether the exception request complies with those procedural requirements cited by HCFA. As stated above, HCFA believed that the Provider's exception request did not consider its home dialysis patients. It is the Provider's position that this finding is patently incorrect and an improper basis for denial.

Contrary to the Intermediary's contention that the Provider omitted the 96 Method I home dialysis patients in computing the patient averages to support atypical characteristics in its exception request, the Provider asserts that information on the 96 Method I home dialysis patients was included throughout its exception request. The Provider acknowledges that the Program instructions require the inclusion of home patient data in an exception request and believes it complied with those requirements. The Provider refers to three (3) program instructions which support its assertion that it complied with the exception request requirements:

> (1) HCFA Pub. 15-1 §2720 provides that home dialysis costs must be included in the analysis of whether a provider's costs exceed its composite rate.
>
> (2) HCFA Pub. 15-1 §2721 sets forth the documentation requirements for the exception request, requires applicants to identify costs associated with services rendered to home dialysis patients, specifically in the area of support services, supplies, dialysis equipment and other costs. See HCFA Pub. 15-1 §2721 (B)(11).
>
> (3) HCFA Pub.15-1 §2725 requires a patient data summary that lists home versus in-facility patients separately. See HCFA Pub. 15-1 §2725. 1 (C).

The Provider notes that the first two requirements cited above relate to inclusion and analysis of it's costs associated with home dialysis patients in the exception request. In support of its contention that information on home dialysis patients was included in its request, the Provider points to Provider Exhibit 1 (which is also Exhibit 1 to the exception request) which contains Provider's FY 1993 Worksheet I-2 as filed with the cost report. At sub-section 1A of that exhibit, the complete I series includes four columns related to home dialysis. Sub-section 1I of that exhibit sets forth the cost per treatment for home continuous ambulatory peritoneal dialysis ("CAPD") and sub-section 1J of that exhibit sets forth the cost per treatment for home continuous cycling peritoneal dialysis ("CCPD"). Finally, sub-section 1K of Exhibit 1 is the complete I series for Provider's home program.

In addition, the Provider notes that the same worksheets provide the projected costs related to the home dialysis programs at Provider's Exhibit 2. See sub-sections 2A, 21, 2J and 2K. Home dialysis costs are also included in the combined outpatient cost per treatment contained at Provider's Exhibit 15.

The third requirement cited above relates to the listing of the Provider's patients segregating out home dialysis patients versus in-facility patients. The Provider contends that its documentation, specifically Exhibits 6A-6D, 8, 19-21, more than adequately satisfied this requirement. See Provider Position Paper at 7-8. The Provider also points out that the listing at Exhibit 6D includes the following information about home dialysis patients: diagnosis code, age, whether the patient is diabetic (DM column heading), whether the patient has hypertension (HTN column heading), the number of admissions, length of stay, date of death and other complications. The Provider contends that the rest of Provider Exhibit 6 (sub-section 6E) provides supporting documentation for the summary information contained at sub-sections 6A through 6D, again, including the home dialysis patients.

Based on the above information, the Provider contends that it more than adequately presented the information for home dialysis patients required by the regulation and manual provisions. The Provider asserts that it is not clear whether the Intermediary and HCFA considered this information. The Provider believes that HCFA's denial does not focus on this information but rather focuses on certain calculations performed and referenced in the narrative.[3] As indicated above, the Provider contends that there is no requirement which requires or provides parameters for such calculations, including whether or not home dialysis patients should or should not be included in such calculations. For the foregoing reasons, the Provider believes it has fully satisfied the applicable requirements with respect to home dialysis patients.

The Provider notes that, even assuming arguendo that the information it included was inadequate by its omission from certain calculations (which Provider in no way agrees with or admits), such information could have been easily requested or calculated. The Provider believes that both the Intermediary and

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[3] See Provider Exhibit 1, pgs. 9-11, see also pg. 2 of HCFA denial letter of July 5, 1994 at Intermediary Exhibit I-3.

HCFA have independent obligations to review an exception request for completeness and to request additional information deemed necessary to perform the review of the exception request. The Provider refers to HCFA Pub. 15-1 § 2723, entitled "Responsibility of Intermediaries," which provides as follows:

> Verify that the exception request contains documentation to support the renal facility's position. Where the renal facility fails to submit the required documentation (§2721), return the exception request to the facility for further development (§2723.3A). The 60 working days will start when the renal facility files an acceptable exception request with all required documentation. (emphasis added)

HCFA Pub. 15-1 § 2723 (Provider Exhibit 35)

The Provider also points to HCFA Pub. 15-1 §2723.3 A which sets forth procedures to be followed by the Intermediary after receiving a facility's composite rate exception request:

> Review the exception request, the cost report, the facility's projected costs and any other documentation submitted by the facility for completeness and accuracy. Where the renal facility fails to submit the required documentation, as required by this Chapter, return the exception request to the facility for further development. ...

Id. (emphasis added)

It is the Provider's position that these provisions clearly impose a burden on the Intermediary to review the exception request as filed and give the requesting provider an opportunity to complete insufficient aspects to the exception request. In this case, the Provider contends that the Intermediary never notified it of any deficiency in the exception request.

The Provider argues further that a similar burden is placed on HCFA by HCFA Pub. 15-1 §2724, entitled "HCFA Central Office Responsibilities":

> Upon receipt of the exception request information from the intermediary, HCFA:
>
> A. Reviews all information submitted;
>
> B. Requests additional information for further development, if needed, to support the exception request;

> C. Prepares a decision based on the documentation submitted and advises the intermediary of the decision or the status of HCFA's review.

HCFA Pub. 15-1 §2724 (emphasis added.) (Provider Exhibit 36)

Moreover, the Provider notes that HCFA Pub. 15-1 § 2721.H provides:

> H. Additional Information. - The facility is responsible for submitting additional information to the intermediary if HCFA has notified it that further development is necessary due to submittal of insufficient documentation to support the exception request. If the facility fails to submit sufficient information to the intermediary, . . . within 180 days, from the date new composite payment rates are effective its exception request will be denied.

HCFA Pub. 15-1 § 272I.H (emphasis added.)

Again, in this case, the Provider asserts that HCFA never notified it of any deficiency in the exception request.

The Provider asserts that the review responsibilities of the Intermediary and HCFA have been confirmed by the Board and the courts. The Provider notes that in University of California San Francisco v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of California, PRRB Dec. No. 95-D18[4], Jan. 25, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,051, remanded HCFA Adm., March, 26, 1995, ("California") the Board found that HCFA failed to complete the review process in accordance with HCFA Pub. 15-1 § 2721.H when it denied a renal facility's exception request for the alleged failure to submit documentation about its actual and projected costs. In its decision, the Board stated:

> The Board finds that fundamental fairness and due process require that notice must be given with respect to the need for additional information under the requirements HCFA published at HCFA Pub. 15-1 §2721.H. However, neither the Intermediary nor HCFA informed the Provider that some documentation had not been included. The Board concludes, based on HCFA's letter of August 1, 1990 (Provider Exhibit F) denying the Provider's exception request, that the Provider was not properly notified of HCFA's perceived deficiencies in the ESRD Exception Request package. Thus, the Provider was not given the opportunity to respond to HCFA's questions as required by the manual instructions at §2721.H.

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[4] Provider Exhibit 37.

Id. at 10 (emphasis added).

The Provider asserts that the same conclusion was reached by the United Stated District Court for the District of Columbia in Mercy Hospital of Miami, Inc. v. Shalala, Case No. 91-3268 (D.D.C. 1993), 1993 WL 475517.[5] The Provider points out that in that case, HCFA denied an exception request submitted for atypical service intensity/patient mix by a renal facility because HCFA found a one-month time study to be insufficient. The court analyzed the obligation of the Intermediary and HCFA to request additional information if either deems the information as submitted to be inadequate. The court found:

> Once HCFA has exercised its discretion in determining that information above and beyond that which is required under § 2721 would be needed to support an exception request, HCFA should at the minimum notify providers and give them an opportunity to supply the additional documentation. Adequate notice and opportunity to comply is the hallmark to administrative fairness. It would be eminently unfair for HCFA to keep a provider in the dark as to the adequacy of the documentation submitted when the provider complies in all respects with the enumerated documentation requirement under pertinent manual provisions. 'Expert discretion is the lifeblood of the administrative process, but unless we make the requirements for administrative action strict and demanding, expertise, the strength of modem government, can become a monster which rules with no practical limits on its discretion.' (citation omitted) (emphasis supplied) Burlington Truck Lines, Inc., 371 U.S. at 167.

Id. at 9 (emphasis added).

Then, specifically addressing the contention of the Intermediary in this case - i.e., the Provider's responsibility to provide a complete exception request - the court found as follows:

> In its delineation of the respective duties of an intermediary and HCFA, the court is cognizant of regulations promulgated by the Secretary pursuant to the Medicare Act, wherein the burden to demonstrate that all criteria for approval of exception request are met is on the provider and not HCFA. (footnote omitted) In light of the voluminous exception requests that await HCFA's review, this policy is sound. ... The court accordingly holds that HCFA, like an intermediary, bears an affirmative duty to request additional information from providers seeking dialysis exception requests when such information is deemed necessary to make the requests approvable.

Id.

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[5] Provider Exhibit 38.

The Provider notes that in its position paper, the Intermediary cites Bronx Lebanon Hospital Center v. Blue Cross/Blue Shield Assn./Empire Blue Cross and Blue Shield, PRRB Dec. No. 96-D48[6], Aug. 12, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,557, ("Bronx Lebanon") for the proposition that it is the responsibility of the provider, not the Intermediary or HCFA, to "perfect" an exception request. However, the Provider points out that this proposition cited by the Intermediary was immediately preceded by the following two sentences: "Within Chapter 27 are instructions that direct the Intermediary and HCFA to request additional information from the provider as needed. HCFA Pub. 15-1 §2723.3. Likewise, the regulation specifies that HCFA will accept an exception request on the date it receives all relevant materials. 42 C.F.R. § 413.170(f)(7)." Id.at 8. Moreover, the Provider contends that in that case, HCFA took more affirmative actions to review the exception request than it did in the present case. As stated at page 6 of the decision, "Despite this deficiency, HCFA performed a de novo review of the request." Id. The Provider contends that there is no indication that such review took place in the case at hand.

The Provider contends that the Intermediary's reliance upon the Bronx Lebanon decision is misplaced for purposes of this case. While the Board in Bronx Lebanon acknowledged the provider's responsibility in perfecting an exception request, this was not the basis for the Board's decision to affirm denial of the exception request. Rather, the Board agreed with HCFA as to several unrelated bases for the denial.

For the foregoing reasons, the Provider submits that HCFA's stated basis for denial - and the sole basis - due to the omission of home dialysis patients from certain percentages cited in the narrative of the exception request, is insufficient. If, in fact, such information was necessary for HCFA to determine whether the request could be approved, the Provider contends that HCFA had an obligation to request that data from Provider.

Perhaps more important, however, the Provider does not believe that either HCFA or the Intermediary needed information beyond what was already presented to perform its analysis.[7] The Provider believes that its presentation of the facts was appropriate and in compliance with the requirements of the Provider Reimbursement Manual. The Provider contends that even if the percentages referenced by HCFA were re-computed in the manner indicated by HCFA (a computation, which the Provider asserts, can easily be performed on the documentation included in the request), the data still supports the atypicality of its service intensity and/or patient mix.

The Provider contends that for each of the percentages that the Intermediary indicated did not include information on home dialysis patients, the information was included in its request and the Intermediary could have used this information. For instance, the Provider notes that the first percentage pertains to

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[6] Intermediary Exhibit I-7.

[7] Provider Position Paper at 13.

the Provider's consistently higher diabetic population. The Provider notes that in its narrative of the exception request, it stated that 42.3% of its patient population was diabetic compared to the national average of 30.9%.[8] The Provider further notes that this percentage (42.3%) was calculated based on its 113 Category I and Category II (all but the home dialysis patients) patients divided by the total Category I and Category II patients (267). The Provider asserts that the number of home dialysis patients who were diabetic - 43 in 1993, is included in its Exhibit 6 (at sub-section 6D). Adding 43 to the numerator (113) and 96 (total home dialysis patients) to the denominator (267) modifies the percentage of its diabetic patients to 42.9%. The Provider contends that this is still well above the national average.

The Provider's Position Paper at pgs. 13-15 includes additional analyses, similar to the above analysis for its diabetic population, for hypertension, age distribution, average length of stay, and mortality. The Provider contends that these additional analyses also support its contention that the information to re-compute the percentages referred to by HCFA in its denial letter, was readily available and support atypicality. The Provider notes that HCFA refused to re-compute the percentages, stating, "We did not recompute the percentages for the patient characteristics ... since it is not HCFA's responsibility to summarize the patient data to make them meaningful." The Provider contends that the analyses described in its Position Paper show (1) how simple it would have been for HCFA to perform these computations; and (2) even as re-computed, the Provider's patient population bears the requisite characteristics of an atypical service intensity/patient mix.

The Provider acknowledges that while home dialysis patients are affected by the composite rate and must be considered in the overall financial analysis of the exception request, they do not and should not be expected to contribute significantly to the atypicality of Provider's service intensity and/or patient mix.[9] The Provider points out that if patients are dialyzing at home, they generally should not have conditions or require treatments which are "atypical." Nevertheless, the Provider agrees that certain parts of the exception request must include information relating to home patients. The Provider contends that it fully and accurately responded to all such elements of the exception request as discussed previously.

The Provider continues its argument that home dialysis patients do not really contribute to "atypicality". The Provider contends that the more specific elements of HCFA Pub. 15-1 similarly do not attempt to identify atypicality with significant emphasis on home dialysis patients. The Provider notes that of the more pertinent provisions to this request, HCFA Pub. 15-1 §§ 2720, 2721 and 2725, all of the guidelines and documentation for demonstrating atypicality explicitly or implicitly focus on the patients treated at the facility. For example, HCFA Pub. 15-1 §2725.1 provides that, in order for an exception request to be granted, any one of five criteria must be met. The five criteria cover the following areas:

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[8] Provider Exhibit 1, pgs. 9-11.

[9] Provider Position Paper at 16.

(1) nursing service hours per treatment; (2) number of employees in the outpatient renal area; (3) supply costs per treatment; (4) overhead costs; and (5) pediatric facilities (not applicable to this request). For each of these areas, the Provider contends that it would reasonably be expected that atypicality will occur with more frequency for in-facility patients rather than home dialysis patients.

The Provider also asserts that HCFA Pub. 15-1 acknowledges that home dialysis does not generally contribute to atypicality where it states:

> The fact that some patients are retained on in-facility dialysis because they lack a suitable partner/aide to assist with dialysis in the home, or the home environment is not readily adaptable, is already recognized in the prospective rate. Therefore, where the facility retains its patients on in-facility dialysis for reasons which do not meet the criteria of the atypical service intensity/patient mix exception, no exception will be approved.

HCFA Pub. 15-1 § 2725.1(D).

The Provider contends that implicit in this statement is the recognition that patients treated in the facility who would otherwise dialyze at home with the appropriate support do not support the need for the exception.

Thus, the Provider contends that its exception request more than adequately demonstrates an atypical patient mix with and without the inclusion of home dialysis patients cited as deficient by HCFA. The Provider requests reversal of HCFA's denial of the exception request for atypical service intensity.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's determination is proper and is based on 42 C.F.R. § 413.170(f)(5) and HCFA Pub 15-1 § 2721. The Intermediary notes that HCFA denied the exception request for atypical service intensity/patient mix since the comparisons made by the Provider gave no consideration to the home dialysis patients.[10] The Provider appealed this determination under 42 CFR § 413.170(h)(2).

The Intermediary refers to HCFA's denial of the exception request which states,

> "To qualify for an exception on this basis a renal facility must demonstrate with convincing objective evidence that its costs per treatment are reasonable and allowable and that the excess costs are directly attributable to the atypical service intensity criterion in 42 C.F.R. § 413.170(g)(1). Further, section 2725.1 of the Provider

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[10] See Intermediary Exhibit I - 3.

> Reimbursement Manual (PRM), requires the renal facility to document the additional items and services furnished to its patients, and the incremental costs associated with these items and services... Based on our review of the provider's documentation (pages 9 - 11) submitted to support the atypicality of its patient population, the Method I home patients (96) were omitted in computing any of the preceding patient averages. When comparing CH's data with the Health Care Financing Administration's (HCFA) national data, the provider only used the total maintenance hemodialysis (267), and unidentified patients treated at CH. It gave no consideration to the 96 home (CAPD and CCPD) dialysis patients. Method I home patients are paid under the composite payment rate and must be included in a patient comparison analysis."

The Intermediary goes on to point out that HCFA's denial further states,

> "We did not recompute the percentages for the patient characteristics... since it is not HCFA's responsibility to summarize the patient data to make them meaningful. According to section 2721 of the PRM, the facility is responsibility (sic) for justifying and demonstrating to HCFA's satisfaction that the requirements and the criteria are met. Therefore, we believe that CH has not submitted evidential documentation to demonstrate that it has an atypical patient mix."

HCFA Exception Request Denial Letter of July 5, 1994 (Intermediary Exhibit I-3).

The Intermediary also notes that HCFA Pub. 15-1 § 2721.D explains that "the facility must submit a schedule combining total outpatient and home maintenance dialysis costs, since the composite rate system is based on a single payment for all outpatient maintenance treatments (in facility and home)."

The Intermediary also points to the regulations at 42 C.F.R. § 413.170(f)(5) which state, "The facility is responsible for demonstrating to HCFA's satisfaction that the requirements of this section, including the criteria in paragraph (g) of this section, are met in full. That is, the burden of proof is on the facility to show that one or more of the criteria are met, and that the excessive costs are justifiable under the reasonable cost principles set forth in this part. The burden of proof is not on HCFA to show that the criteria are not met, and that the facility's costs are not allowable." Id.

Likewise, the Intermediary refers to the program instructions at HCFA Pub. 15-1 § 2721 which state, "The facility is responsible for justifying and demonstrating to HCFA's satisfaction that the requirements and the criteria listed in these instructions are met in full. That is, the burden of proof is on the facility to show that one or more of the criteria are met, and that the facility's costs, in excess of its composite rate, are justifiable under reasonable cost principles." Id.

The Intermediary believes that HCFA has properly denied this exception request and asks that the Board uphold the denial in the current case as it did in Bronx Lebanon That decision states, ". . . Both authorities also state explicitly that the burden of proof is on the provider to demonstrate that an

exception is warranted. 42 C.F.R. § 413.170(f)(5) and HCFA Pub. 15-1 § 2721. Neither the Intermediary nor HCFA is responsible for perfecting an exception request". Id.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Regulations-42 C.F.R. :

§§ 405.1835-.1841.	-	Board Jurisdiction
§ 413.170 et seq.	-	Payments for covered outpatient maintenance dialysis treatments.

2. Provider Reimbursement Manual, Part 1 ("HCFA Pub. 15-1"):

§ 2720 et seq.	-	General Instructions for Processing Exceptions under Composite Rate Reimbursement System.
§ 2721 et seq.	-	Exception Requests-All Facilities
§ 2725 et seq.	-	Specific Instructions for Adjudicating ESRD Exception Request
§ 2723 et seq.	-	Responsibility of Intermediaries
§ 2724	-	HCFA Central Office Responsibilities

4. Cases:

University of California San Francisco v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of California, PRRB Dec. No. 95-D18, Jan. 25, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,051, remanded HCFA Adm., March, 26, 1995.

Mercy Hospital of Miami, Inc. v. Shalala, Case No. 91-3268 (D.D.C. 1993), 1993 WL 475517.

Bronx Lebanon Hospital Center v. Blue Cross/Blue Shield Assn./Empire Blue Cross and Blue Shield, PRRB Dec. No. 96-D48, Aug. 12, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,557.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions and evidence presented, finds and concludes that HCFA, by limiting its review of the Provider's exception request to only a few pages of the narrative portion of the request, improperly denied the Provider's request for an exception to the ESRD composite rate based on atypical service intensity under 42 C.F.R. § 413.170 (g)(1). The Board finds that the issue in this case appears to be HCFA's perception regarding the presentation and apparent lack of home dialysis patient information in summary data that was used to compute certain percentages to indicate atypical service intensity. The Board also finds that the Provider's appeal of HCFA's denial of its exception request was filed in a timely manner.

The Board notes that the Provider and Intermediary have stipulated that the sole basis for the denial of the exception request was HCFA's, "belief that the Provider failed to sufficiently consider the home dialysis patients."[11] The Board finds evidence that indicates HCFA based its review of the Provider's documentation, submitted to support atypical service intensity, on pages 9-11 of the narrative portion of the Provider's exception request.[12] Consequently, the Board finds that HCFA's review failed to consider data on the Provider's home dialysis patients that was included throughout the exception request package, beyond pages 9-11 of the narrative portion of the request. The Board finds evidence to indicate that cost and treatment data, for the Provider's home dialysis patients, was included in the schedules and exhibits of the Provider's exception request package. Specifically, the Board finds that Exhibit 15 includes cost and treatment data that is summarized for all type of patients, including the home dialysis patients.

The Board notes that the Provider does not dispute the Intermediary's assertion that statistics on home dialysis patients were not included in the calculation of certain percentages, shown to support atypicality, in the narrative portion of its request. However, the Board finds that there is sufficient evidence in the Provider's Exhibit 6D, which was part of the exception request, to indicate that home dialysis patient information was readily available for inclusion in the summary schedule of atypical service intensity percentages, as shown by the Provider in the narrative portion of its request (pgs. 9-11) and on page 2 of HCFA's denial letter.[13] The Board also finds sufficient evidence in the record to corroborate the Provider's statistics on home dialysis patients as discussed on Pages 13-15 of its Position Paper. The Board notes that it was the Provider's argument in the aforementioned portion of its Position Paper that information on the home dialysis patients was easily obtainable from the schedules included with the exception request, and using this information to recompute the percentages, still supported the Provider's contention that it had an atypical service intensity/patient mix. The Board agrees with the Provider's argument.

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[11] See "Joint Stipulation" dated July 23, 1999, item no. 8.

[12] See HCFA Denial Letter Dated July 5, 1994, pg.2 at Intermediary Exhibit I-3.

[13] Id.

The Board finds that HCFA Pub. 15-1 § 2723, entitled "Responsibility of Intermediaries," required the Intermediary to:

> Verify that the exception request contains documentation to support the renal facility's position. Where the renal facility fails to submit the required documentation (§2721), return the exception request to the facility for further development (§2723.3A). The 60 working days will start when the renal facility files an acceptable exception request with all required documentation.

HCFA Pub. 15-1 § 2723 (Emphasis added).

In addition, the Board finds that HCFA Pub. 15-1 §2723.3A sets forth procedures to be followed by the Intermediary after receiving a facility's composite rate exception request:

> Review the exception request, the cost report, the facility's projected costs and any other documentation submitted by the facility for completeness and accuracy. Where the renal facility fails to submit the required documentation, as required by this Chapter, return the exception request to the facility for further development. ...

HCFA Pub. 15-1 §2723.3A (Emphasis added).

The Board also finds that a similar burden is placed on HCFA by HCFA Pub. 15-1 §2724, entitled "HCFA Central Office Responsibilities":

> Upon receipt of the exception request information from the intermediary, HCFA:
>
> A. Reviews all information submitted;
> B. Request additional information for further development, if needed, to support the exception request;
> C. Prepares a decision based on the documentation submitted and advises the intermediary of the decision or the status of HCFA's review.

HCFA Pub. 15-1 §2724 (Emphasis added).

The Board finds no evidence in the record to indicate that HCFA or the Intermediary provided any feedback to the Provider, as required by the above program instructions, of their perception that the exception request failed to consider data on home dialysis patients, which HCFA deemed was necessary to support the exception request.[14] The Board realizes that the burden of proof is not on

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[14] The Board notes that the May 5, 1994 letter from the Intermediary to HCFA, which transmitted the Provider's exception request and presumably included the

HCFA or the Intermediary to perfect a provider's exception request, however, the Board finds that both parties have a responsibility to inform the Provider when they perceive an apparent lack of documentation exists. The Board finds that had HCFA notified the Provider of its perception that data on the home dialysis patients was omitted in the computation of certain percentages, the Provider could have easily recomputed the percentages and/or pointed HCFA to the section of the exception package where the information was included. Thus, the Provider was not given the opportunity to respond to HCFA's concerns as required by the program instructions at HCFA Pub. 15-1 § 2721H.

Based on the its analysis of the record, the Board concludes that sufficient information was submitted to the Intermediary and HCFA to support atypicality and approve the exception request. As noted above, the Board finds that when the percentages are recomputed[15] using home dialysis patient data, the percentages still support atypicality. Specifically, the Provider's documentation did in fact sufficiently consider home dialysis patients, which was the sole basis, as stipulated by the Provider and the Intermediary, for HCFA's denial.

Regarding the Intermediary's argument that HCFA Pub. 15-1 § 2721.D requires that "the facility must submit a schedule combining total outpatient and home maintenance dialysis costs, since the composite rate system is based on a single payment for all outpatient maintenance treatments (infacility and home)", the Board finds that the Provider did in fact submit such a schedule at Exhibit 15.

Regarding the Intermediary's reference to the Bronx Lebanon decision and how it supports its position in the current case, the Board finds that this case was based on a deficiency in the provider's exception request and cost report data, which in the Board's opinion, distinguishes from the current case. The Board finds that the current case did not suffer from the paucity of information evidenced in the Bronx Lebanon and California cases.

The Board does note, however, the similarity of the issue in the current case and the comments of the HCFA Administrator's decision in California, in which the Administrator stated:

> [n]evertheless, the Administrator finds that the record suggests that the Provider may have furnished sufficient data to support its exception request but presented the data in a manner that did not conform completely to routine reporting requirements. . .

Intermediary's recommendation for approval/denial and/or comments on inadequate documentation, was missing from the record.

[15] See Provider Position Paper pgs. 13-15.

DECISION AND ORDER:

The Board finds that HCFA's denial of the Provider's request for an exception to the ESRD composite rate based on atypical service intensity, because "Method I home patients (96) were omitted in computing any of the preceding patient percentages,"[16] was improper. Therefore, HCFA's determination is reversed and the Intermediary is ordered to approve the Provider's request for an exception based on atypical service intensity.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: December 8, 1 19999

FOR THE BOARD:

Irvin W. Kues
Chairman

[16] See HCFA denial letter of July 5, 1994; Intermediary Exhibit I-3.