PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D47

PROVIDER –
Schoolcraft Memorial Hospital
Manistique, Michigan

Provider No. 23-0115

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
United Government Services, LLC - CA

DATE OF HEARING -
December 7, 2001

Cost Reporting Periods Ended
December 31, 1992
December 31, 1994

CASE Nos. 00-3139
01-2861

INDEX

ISSUE:

Was the Intermediary's denial of the Provider's request for additional payment for decreased discharges proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Schoolcraft Memorial Hospital, (the "Provider") is a not-for-profit general short-term acute care hospital, located in Manistique, Michigan. During the periods under appeal, the Provider was a "Sole Community Hospital" under the terms of the regulations. The Provider sought a low volume adjustment to its DRG payment pursuant to 42 C.F.R. 412.92(e) for fiscal years ending ("FYE") 12/31/92 and 12/31/94 due to a decrease in discharges of 5.5% for an inability to recruit essential physician staff. United Government Service -WI (the "Intermediary") denied the Provider's request for FYE 12/31/92 because it concluded that the Provider's decline in discharges was the result of a shift to outpatient services and not a result of an inability to recruit essential physician staff. For the 12/31/94 cost-reporting year, the Intermediary found that the Provider qualified for a low volume adjustment under 42 C.F.R. § 412.92(e). However, after adjustment to the Provider's costs to remove the costs of excess staffing, no payment was actually due.[1]

The Intermediary's denial for a low volume adjustment afforded to qualifying Sole Community Hospitals resulted in a decrease in Medicare reimbursement of $263,448 for FYE 12/31/92 and $295,040 for FYE 12/31/94.[2]

The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Ronald Rybar, C.P.A. of The Rybar Group. The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

FYE 12/31/92

The Provider asserts that it clearly met the requirements set forth in HCFA Pub.15-1 § 2810.1. The Provider had experienced the loss of a radiologist, inability to recruit a female obstetrician ("OB") admitting physician and the loss of a Certified Registered Nurse Anesthetist ("CRNA") that was clearly beyond the control of the Hospital. Inability to recruit essential physician staff is detailed in this section as an occurrence that triggers an additional payment.

In addition, the Provider could not be run effectively without adequate radiology coverage. The Provider had daily (five days per week) radiology coverage through

[1] See Intermediary post-hearing brief page 2.
[2] See Provider post-hearing brief page 3.

November, 1991 through an arrangement with Marquette General Hospital ("MGH"). A heart attack to one of the physicians covering MGH forced it pull its radiology coverage. Schoolcraft Memorial Hospital ("SMH") was reduced to only one day per week coverage. At times, the Provider had to box up films and send them to MGH to get them read.

The Provider claims that there is documentation of its efforts to recruit a radiologist. Recruiting a radiologist who wants to live in a rural area, making less than their peers, is difficult. In addition, there is a letter from 1986 that details the displeasure of the medical staff with the radiology service. Essentially the same group of physicians was on staff in 1992. The Provider's witness testified that physicians were telling him that patients would be sent elsewhere without better coverage. This fact supports the Provider's position. The witness had been the Provider's Chief Executive Officer ("CEO") during this entire period, and his view of the situation was reflective of actual hands-on experience related to these issues. The rest of the witnesses for both parties were only "looking at the numbers" and had not been directly involved.

The Provider claims that by the time the new radiologist started (April, 1992), discharges had already decline by almost 60% for the year (29 of 48). March of 1992 was the lowest volume discharge month of that year, and this was the month immediately preceding the start date for the new radiologist.

The Provider notes that the Intermediary makes the assertion that growth in outpatient revenue is indicative of the fact that patient volume was changing from inpatient to outpatient, and that this was the reason that inpatient volume declined. The following facts are germane:[3]

1) The Provider's percentage of market share in Schoolcraft County fell by 5.8% (72.9% to 68.7%). This fact alone numerically explains almost all of the Provider's decline in discharges. The total inpatient discharges were flat in the county in 1992. This refutes the Intermediary's assertion that there was a substitution effect of inpatient to outpatient. The volume of inpatient services in the county was virtually identical for both years. Only the Provider had a change in inpatient discharges.

2) The Provider's admissions from the county fell by 1.7% from 1991 to 1992. This was reflective of the fact that there was a loss of market share.

3) Transfers from the emergency room ("ER") increased by 28%, which was reflective of lack of radiology coverage.

4) Core radiology procedures without new services and CT Scan (the Provider acquired fixed service during appeal period - converted from mobile) were down

[3] See Provider's post-hearing brief page 5.

8.2% in 1992. Even including CT Scan (heavily outpatient), radiology procedures were down 1.9% from 1991 to 1992.

The increases were in mammography (heavily outpatient and never inpatient) and Nuclear Medicine (mostly outpatient and a new service). The reading of mammograms is generally not time sensitive and would not be impacted in the same manner as inpatient films.

5) The Provider had a 3.2% decrease in percentage of patients admitted through ER. This would support the fact that a greater number of patients were transferred because of limited radiology coverage.

6) The three major admitting physicians, who had also signed the 1986 radiology letter, had reduced 1992 admissions over 1991. The range was 19.3% to 32.2%. The former CEO testified that their office practices appeared to be the same. The county admissions were the same. The Provider didn't get the patients.

The Provider states that its medical staff reports in the board minutes confirmed that it was losing female patients because it did not have a female family practitioner that performed OB. Thirteen of the 48 overall Provider discharge count drop (27%) was in the OB area, as deliveries fell from 142 in 1991 to 129 in 1992. This was a 9% decrease from 1991 to 1992. There were numerous references and sufficient documentation of the Provider's recruiting efforts. This situation was equivalent to the loss of a physician, because the capability of providing services to females who want a female OB/GYN was not available at the Provider's facility. The market was moving, as the Provider did not have these services.

The loss of a CRNA in late 1992 caused a reduction in inpatient surgical procedures. The board minutes detail the difficulty in scheduling procedures after the one CRNA had left the facility. This further contributed to the inpatient admission decline, as the number of inpatient surgical procedures was less in 1992 than in 1991.

FYE 12/31/94

The Intermediary agreed that the Provider met the requirements in HCFA Pub. 15-1, § 2810.1.B, which states that an additional payment is made including the reasonable cost of maintaining necessary core staff and service. In both the 1992 and 1994 requests under Section IID, 2 A&B, the Provider provides extensive detail regarding the core staff required to run the Hospital. This detail was not challenged by the Intermediary as unreasonable.

The Provider points out that the cost reports in question were finally settled by the Intermediary with minor revisions. These final settled reports were the basis upon which the requests for $263,546 in 1992 and $295,040 in 1994 were made. There were no audit adjustments made due to the fact that any costs in the cost report were not reasonable. Absent any such adjustments, one assumes that the costs in the cost

report were reasonable and met the test of reasonability detailed in HCFA Pub. 15-1 § 2810.1.B.

The Provider contends that HCFA Pub. 15-1, Section 2810.1.B also indicates that the "Intermediary reviews the determination of core staff and services based upon an individual hospital's needs and circumstances, e.g., minimum staffing imposed by state agencies." The Provider has provided data to show that for 1992 its absolute minimum staffing was 11.6 hours per patient day and the actual was 13.6 hours. The actual hours worked include staffing for patient volume above the minimum and would always be higher than minimum. In 1994, because of continued volume declines, the comparable numbers are 16.4 minimum and 20.65 hours worked. In both cases, the actual is in the 20% range of the minimum, clearly explainable by fluctuations in patient census.

HCFA Pub. 15-1, § 2810.1.C.6 of the regulation requires submission of core staff and a comparison of staffing from year to year. The relevant cost centers and respective FTE percentage change amounts from the previous year are shown as follows:

	1992	**1994**
Adults and Peds	(10.7%)	(1.9%)
Nursery	0.00%	0.00%
O.R.	21.4%	1.2%
Anesthesia	(7.0%)	55.3%
E.R.	0.00%	0.00%
TOTAL Hospital	(0.9%)	0.7%

For both years in question, the Provider claims that its Adult and Pediatric staff are reduced and overall staff was relatively flat. This is in spite of the fact that outpatient visits rose 16.2% in 1992 and Home Health, Clinic, and Nuclear Medicine services were added in 1994.

HCFA Pub. 15-1, § 2810.1.C.a indicates that core nursing staff is determined by comparing full-time equivalent (FTE) staffing in the Adults and Pediatrics and Intensive Care cost centers to FTE staffing in the prior year and FTE staffing in Peer Hospitals. Peer Hospital information is obtained from data on nursing hours per patient day from the Hospital Administrative Statistics ("HAS") Monitrend data books for hospitals of the same size, geographic area (census division), and period of time."

The Provider produced a letter from the American Hospital Association ("AHA") indicating that this data, specifically for the years in question, is no longer produced. The Intermediary indicates that they used prior year data (1988) for this comparison. Even if one accepts the premise that 3 to 4 year-old data meets the requirements of the regulation, the data utilized does not reflect peer hospitals because hospitals without OB services are included in the data, skewing the results.

The Provider utilized the AHA Statistical Report, which encompassed hospitals of the same census division and time period, as required by the regulation. This data, unfortunately, is not specific to only the Adult, Pediatric and ICU cost centers.

In addition, the Provider provided data as detailed above showing that its staffing was reasonable, based upon "its own needs and circumstances," as required in HCFA Pub. 15-1 § 2810.1.B. The Intermediary ignored the Providers's documentation for this item.

The Provider believes that HCFA Pub. 15-1 § 2810.1 is designed to act as a safety net for payment of reasonable cost to hospitals designated as Sole Community or Medicare Dependent. The hospitals affected by the regulation tend to be small, rural and economically fragile. In addition, they are very vulnerable to inpatient volume reductions, particularly due to physician recruiting issues. Denial of payment under 2810.1 by the Intermediary, without a clear-cut path to do so, is inconsistent with the intent of the regulation.

The Provider contends that it is fairly well established that the purpose of the payment adjustment is to ensure that a Sole Community Hospital is reimbursed for all of its fixed costs for the care of inpatients, and particularly, the costs of maintaining core staffing. This is the crux of the Provider's request.

This regulation was a precursor to Critical Access Hospitals ("CAH"). CAH are now paid full reasonable cost by Medicare. The Provider is a CAH.

The Provider insists that the Intermediary, in its analysis of core nursing staff, used an average of 1989 and 1990 nursing hours per day for hospitals with under 50 beds and for census division 4. The nursing hours per patient day used for the 1994 calculation were 10.54. Per the Intermediary, this core staff included both nursing and support staff, i.e., RN, LPN, Ward Clerk and Nurses Aides.

The Provider, in its analysis of core nursing staff, used American Hospital's Association ("AHA") data from 1992 and 1994 for the State of Michigan and for the appropriate number of staffed beds. The nursing hours per patient day used for the respective core staff calculations were 26.18 for 1992 and 26.02 for 1994.

AHA data is used for many Medicare purposes, including the Medicare Geographical Classification Review Board ("MGCRB") reclassification process. The data (wages and hours) utilized for Occupational Mix Comparisons is accumulated by the AHA. AHA guidelines are also utilized for asset useful lives which is used for Medicare reimbursement purposes and for general ledger charts of accounts. This lends credibility to the AHA data. What lends even more credibility is the fact that the Monitrend data used by the Intermediary was also the product of an ongoing survey conducted by the AHA.

In a small rural hospital, even though there may be only one or two patients in the hospital, a minimum number of staffing is still necessary. Therefore, in a period of declining volume, nursing hours per patient day will actually increase because the staffing must remain constant. Having an OB unit magnifies this, as there must be at least one additional nurse if there is a patient in OB.

The Provider also reviewed its own actual nursing hours per patient day as described in the previous section. The Provider's minimum staffing levels are reviewed by a state agency ("JCAHO") on a regular basis to ensure that the Provider is being staffed at a level to operate safely. This minimum staffing was, again, 11.6 for 1992 and 16.4 for 1994. This minimum does not even consider that there may be a patient in OB, which would require an additional nurse. The actual nursing hours per patient day were 13.6 for 1992 and 20.65 for 1994. These minimum and actual hours per patient day include RN's and LPN's only. This, once again, shows that Provider staffing based upon "its own needs and circumstances" was reasonable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the Medicare regulation at 42 C.F.R. § 412.92(e) provides for additional payments to sole community hospitals that experience at least a 5% decrease in discharges, as compared to the previous cost reporting year, due to "circumstances" beyond the hospital's control. The HCFA Pub.15-1 §2810.1 defines the term "circumstances beyond the hospital's control" as unusual circumstances externally imposed on the hospital. Examples of unusual circumstances include, among other things, inability to recruit essential physician staff.

The Intermediary asserts that for the 1992 cost-reporting year, the Provider has claimed that the inability to recruit essential physician staff was the cause of the 5% decrease in discharges from the prior year.[4] Essential physician staff, for purposes of § 2810.1, refers to admitting physicians, since it is the admitting physicians' who affect discharge statistics.[5] However, the Intermediary compared the Provider's physicians in 1991 and 1992 and found that the admitting physicians were exactly the same in both years.[6] If there was no change in the admitting physicians from 1991 to 1992, then the decline in discharges cannot be tied to the fact that a physician was not at the hospital, admitting patients. Since the group of physicians who were responsible for admitting patients to the hospital had remained stable during the years under review, the Intermediary concluded that the decline in discharges in 1992 was not the result of an inability to recruit essential physicians.

The Provider argued that the loss of a radiologist, or unavailability of radiology services, resulted in the decline in discharges. The Intermediary contends that

[4] See Trans. p. 11.
[5] See Trans. p. 166-7.
[6] See Trans. p. 163.

radiologists do not constitute essential physician staff because they are not admitting physicians; and even if radiologists were considered essential physician staff, this Provider was never without radiology services during the period under appeal. Prior to 1992, the Provider obtained radiology services through radiology groups on a part-time basis. In 1992, the Provider had a full-time radiologist on staff.[7] Further, in 1992, radiology procedures increased by 11.[8] From the Intermediary's review of hospital board minutes and other documents, there was no indication of any period in which radiology services were not readily available. The Intermediary further opined that if the lack of radiology services were affecting the hospital's ability to admit patients, one would expect to see some evidence of that documented in hospital records, such as board minutes. In fact, no such documentation was ever found or supplied as a part of this case.[9]

The Intermediary asserts the Provider also claimed that the lack of an additional female family physician offering obstetric services resulted in a decrease in discharges. The Intermediary believes this had nothing to do with the decrease in discharges, since the Provider had never had such a physician on staff. Hiring another family practice physician would not have been because one of the admitting physicians had left, but would have been an addition to the staff. The Intermediary also pointed out that there was no evidence of a recruiting effort for such a physician.[10]

The Intermediary contends that the decline in discharges is the result of a shift in services from inpatient to outpatient, and that such a shift to outpatient services was part of a national trend during this period. In fact, hospitals were given incentives through payment arrangements to move services to an outpatient setting.[11] From 1991 to 1992, outpatient revenue as a percentage of total revenue increased from 47.7% to 54.1%. Total outpatient visits increased by 16%.[12]

The Intermediary insists that a shift from inpatient to outpatient services is not a qualifying event under 42 C.F.R. § 412.92(e) and HCFA Pub. 15-1 §2810.1 because it is not an unusual event, externally imposed on a hospital and beyond the hospital's control. In fact, the Provider's witness indicated the hospital intentionally worked to develop and expand its outpatient services.[13] Certainly, the Provider was fully aware of the shift from inpatient to outpatient services and was in a position to adjust core staffing at the hospital to reflect that change. As a result, decreases in discharges and the costs associated with that decrease was not outside the control of the Provider.

---

[7] See Trans. p. 165.
[8] See Trans. p. 166.
[9] See Trans. p. 172.
[10] See Trans. p. 174.
[11] See Trans. p.170.
[12] See Trans. p. 178-180.
[13] See Trans. p. 82-3.

The Intermediary notes that during the 1994 cost-reporting year, an admitting physician left the Provider's staff. As a result, the Intermediary concluded that in 1994 the Provider's decrease in volume was the result of an unusual circumstance beyond the Provider's control. The disagreement between the parties concerns the use of Hospital Administrative Statistics ("HAS") Monitrend Data Books for purposes of comparing the Provider's core nursing staffing to peer hospitals pursuant to HCFA Pub. 15-1 § 2810.1.C.6.a. That Manual provision requires that the Intermediary review core staffing by comparing the hospital's actual staffing to its staffing in the year prior to that in which it is seeking a low volume adjustment, as well as a comparison to staffing in peer hospitals. The Manual requires the use of HAS Monitrend data for purposes of comparison to peer hospitals.[14]

The Intermediary asserts that the Provider has attempted to use data developed by the AHA in 1994. The Intermediary disagrees with the use of the 1994 data for several reasons. First, the Manual provision is specific in its instruction to use the HAS Monitrend data. Second, the Provider's proposed AHA Report includes total staffing across the reporting facilities. The Provider then attempts to reduce the average FTEs by Provider specific data in order to adjust the AHA data back to FTEs in routine areas.[15] The AHA report includes providers other than hospitals in its data. For example, the report includes FTEs in hospital-based skilled nursing facilities.[16] All of this raises questions as to whether the 1994 AHA Statistical Report accurately reflects staffing in routine areas of peer hospitals. Finally, the Intermediary was unable to obtain any information or backup documentation on what was included in the 1994 Report or how the data was compiled. While the HAS Monitrend data may be older than the 1994 AHA Report, the Intermediary believes it more accurately reflects staffing in peer hospitals. The Intermediary points out that while the HAS Monitrend data was from the late 1980s, it may very well be more generous in its assumptions about staffing in peer hospitals. This is because, with the advent of PPS, hospitals have typically been reducing staffing in routine areas to reflect the fact that reimbursement levels were relatively fixed.[17]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.92(e)	-	Special Treatment-Sole Community Hospital

2. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

[14] See Trans. p. 191.
[15] See Trans. p. 196-7.
[16] See Trans. p. 197.
[17] See Trans. p. 193.

§ 2810.1 et seq. - Additional Payments to SCHs that Experience a Decrease in Discharges

3. Other:

Hospital Administrative Statistics Monitrend Data Books
AHA Statistical Report

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, evidence presented and post-hearing briefs, the Board finds and concludes as follows:

FY 1992

The majority of the Board finds that the Provider's factual situation allows it to qualify for additional reimbursement due to its decrease in discharges from FY 91 to FY 92. It meets the requirements of 42 C.F.R. § 412.92(e) in that its discharges of inpatients exceeded the five percent threshold required by the regulation. The Board majority notes that the five percent decline was undisputed in this case. In addition, the Provider has also demonstrated that the decrease was due to circumstances beyond its control as required by 42 C.F.R. § 412.92(e)(2)(ii) in that its limited radiology coverage caused the reduction in discharges.

Problems with radiology coverage began in 1986.[18] In a letter to the Administrator of the hospital, signed by seven admitting physicians, they complained that limited radiology coverage made it impossible for them to feel comfortable that the hospital would be able to provide the necessary radiology services to ensure proper patient care.

The Provider submitted evidence that it made several different arrangements to recruit physicians. This included having a radiologist from Atlanta, Georgia commute to provide some weekday coverage. However, coverage remained somewhat erratic until the Provider was able to contract with a radiology group that covered three hospitals.

In November, 1991, one of the contract radiologists had a heart attack and the group reduced the Provider's radiology coverage to only one day per week. At times, the provider had to box up films and send them to another hospital to get them read; X-rays were accumulating 4 ½ - 5 days before being read. The CEO testified that admitting physicians complained about the uncertainty, making it very difficult to admit patients needing any type of radiological services.[19] Three of the admitting

[18] See Provider Exhibit P-3A.
[19] See Trans p. 29.

physicians who signed the 1986 letter (included 9 physicians signatures) were still on staff in 1992.[20] Given these facts, it appears reasonable that discharges would decline, since patients who needed immediate radiological services would not be admitted to this hospital. The Provider did attempt to bolster its radiology coverage while it recruited a full-time radiologist, but had no success until Dr. Grillo was hired in late March, 1992. The month immediately preceding his employment was the lowest volume discharge month of the year. Thus, the Board majority believes that the Provider efficiently attempted to deal with this problem in this difficult circumstance.

Regarding the Intermediary's arguments that the Provider's decline in discharges was due to a shift from inpatient to outpatient services, the Board majority notes that even if this were true, this circumstance is not within the Provider's control. The Board majority points out that there is no evidence in the record to associate the outpatient volume increase with the decline in discharges. The Board majority notes that the hospital's percentage of market share in Schoolcraft County fell by 5.8% (72.9% to 68.7%).[21] This fact alone explains most of the Provider's decline in discharges. The total inpatient discharges were flat in the county in 1992. This refutes the Intermediary's assertion that the decline in discharges was due to a shift from inpatient to outpatient services. In addition, transfer of patients from the emergency room increased by 28%, which was reflective of the lack of radiology coverage.

The Board majority finds that HCFA Pub. 15-1 § 2810.1 applies to the Provider's situation. That section deals with the special treatment of Sole Community Hospitals under the HCFA Prospective Payment System. Essentially, HCFA Pub. 15-1 § 2810.1.A.2 is the same as 42 C.F.R. § 412.92(e). However, HCFA Pub. 15-1 § 2810.1.A.1 offers examples of circumstances beyond a provider's control. One of those examples cited was "inability to recruit essential physician staff." As addressed above, the Provider has met this requirement. HCFA Pub. 15-1 § 2810.1.A.2 requires the Sole Community Hospital to experience a decrease in discharges of more than five percent. The decrease in Provider's discharges was 5.5%.[22] Therefore, the majority of the Board concludes, based on the Provider's arguments and supporting documentation, that it has met the necessary requirements set forth in the Medicare regulations and guidelines to qualify for a low volume adjustment.

FY 1994

The issue before the Board regarding FY 1994 concerns the most reliable data source used for purposes of comparing the Provider's core nursing staffing to peer hospitals pursuant to HCFA Pub. 15-1 § 2810.1.C.6.a. Based on the Board majority's analysis of staffing ratios, the HAS Monitrend data books appears to be the most reliable data source. The Board majority notes that the AHA discontinued the HAS Monitrend Data Books in 1993, and the Intermediary used 1991 HAS data with update factors for comparison purposes in its analysis.

[20] See Provider's Exhibit P-3A.
[21] See Provider post-hearing brief, page 5.
[22] See Provider Exhibit P-2.

Since the HAS Monitrend Data Books were not available for the fiscal year at issue, the Provider utilized AHA data from Michigan hospitals in the same census division and time period and with the appropriate number of staffed beds. Based on the AHA data, the nursing hours per patient day used for the respective core staff calculations was 26.02 for 1994. However, the AHA data is not specific to only the Adults and Pediatrics and ICU cost centers, as required by HCFA Pub. 15-1 § 2810.1.C.6.a, which states:

> [c]ore nursing staff is determined by comparing full-time equivalent (FTE) staffing in the Adults and Pediatrics and Intensive Care cost centers to FTE staffing in the prior year and FTE staffing in Peer Hospitals. Peer Hospital information is obtained from data on nursing hours per patient day from Hospital Administrative Statistics (HAS), Monitrend data books for Hospitals of the same size, geographic area (census division), and period of time.

The Board majority notes that AHA data utilized by the Provider did not meet the requirements set forth in the manual provisions mentioned above. In addition, when questioned at the hearing about the AHA survey, the Provider's witness was unable to provide any information at to its contents. However, the Board majority also notes that the HAS Monitrend Data Books included in its survey hospitals without OB services, as this Provider offered OB services. Therefore, the Board majority notes that in this particular case each survey has its differences with the specific requirements of HCFA Pub. 15-1 § 2810.1.

The Board majority finds that there was not sufficient conclusive evidence in the record concerning the Michigan state minimum staffing requirements pursuant to HCFA Pub. 15-1 § 2810.1.B, which states, in part:

> [t]he intermediary reviews the determination of core staff and services based on an individual hospital's needs and circumstances; e.g., minimum staffing requirements imposed by State agencies.

Although the Provider furnished internal policies regarding minimum staffing requirements, the Board majority found these documents inadequate to calculate minimum staffing levels as there was no evidence of daily census and acuity level reports. After reviewing the Nursing Service Staffing and Patient Classification document, the Board majority notes that if the acuity level of the Provider was extensive (level III), then it would require 7 nursing hours of care/patient, in comparison to the Provider's actual 20.64 nursing hours of care/patient. The Board majority finds the variance between the two documents to be quite significant with no evidence presented to account for the disparity.

In conclusion, the Board majority finds that in comparing the 1991 HAS paid nursing hours per patient day of 10.54[23] to the 26.02 nursing hours per patient day as evidenced by the AHA Hospital Statistics Report,[24] the 10.54 nursing hours per patient day appears to be more reasonable. The Board majority finds that the Intermediary's analysis appears to be more reliable and accurate for typical staffing of a medical surgical hospital.

DECISION AND ORDER:

FYE 1992

The Provider is entitled to additional reimbursement due to a reduction in discharges. The Intermediary's determination is reversed.

FYE 1994

The Intermediary used the best available data source, HAS Monitrend data books, therefore, the Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire (Dissenting)
Stanley J. Sokolove
Gary Blodgett, D.D.S.
Suzanne Cochran, Esquire

Date of Decision: September 27, 2002

FOR THE BOARD

Irvin W. Kues
Chairman

[23] See Intermediary position paper Exhibit I-2.
[24] See Provider's Exhibit P-9.

Wessman dissent-in-part

This Decision covers the two above-referenced PRRB appeals with one issue: Was the Intermediary's denial of the Provider's request for additional payment for decreased charges proper? The PRRB Majority chose to issue two "Decision(s) and Order(s)", one for FYE 1992 (CN: 00-3139) and one for FYE 1994 (CN: 01-2861).

I CONCUR with the Majority Decision to uphold the FI's determination in FYE 1994; I DISSENT from the FYE 1992 Majority Decision reversing the Fiscal Intermediary's adjustment.

This case involves the payment of bonus Medicare Trust Fund dollars to any sole community hospital that experiences a yearly drop of at least 5% in discharges, as compared to the prior year, providing such drop can be proven to be ". . .due to circumstances beyond the hospital's control". 42 C.F.R. § 412.92(e)(2)(ii) I find the fact pattern in the instant case to be one that demands that the Provider present strong evidence demonstrating that the circumstances were beyond it's control before receiving an award of $263,448 additional bonus Medicare funds. I do not find that the Provider has met that burden in the instant case.

HCFA Pub. PRM 15-1 §2810.1(A)(1) provides promulgated regulatory guidance for interpretation of 42 C.F.R. § 412.92(e)(2)(ii). The Provider correctly notes that "inability to recruit physician staff" is an example of a "circumstance beyond the control" of the SCH. But "inability" and "inactivity" are not synonyms. The Provider has not presented evidence that would suggest an aggressive or even active recruiting process in place during the time-frame for impact on the FYE '92 decrease. Intermediary's Position Paper, Exhibits 4, 5, & 6. The Provider also asserts that lack of Radiology, not lack of core Admitting Physician staff, was the basis for the decline. But the record shows that radiographic procedures actually increased 10.7% from 1991 to 1992. Intermediary Position Paper at 4; Tr. at 166. The record also shows that the Admitting Staff remained stable during the decline, with no attempt to recruit additional Admitting Staff. In fact, there was a hint that if additional Admitting staff were recruited, it would "reduce income of existing MD's". Intermediary Position Paper, Exhibit I-5.

There was some suggestion from the Provider that the lack of Radiology at Schoolcraft dampened the Admitting Staffs' enthusiasm for admitting local patients to the local hospital, and the inference made that there were ". . .two hospitals located about 60 miles away and one 55" where ostensibly the 5% reduction may have gone (Tr. at 93), but none of the Schoolcraft Admitting Physicians who expressed concern about the lack of Radiology at Schoolcraft in an anachronistic letter of 1986 (Provider Position Paper, Exhibit P-3A) had admitting privileges at any of the three neighboring hospitals in 1992 (Tr. at 93), so they would have had to refer the local patient to a neighboring primary care physician if that local patient was going to be admitted elsewhere – a doubtful occurrence in today's highly competitive healthcare world. In addition, the fact that the hospital's

administration was ostensibly "put on notice" in 1986 regarding a perceived lack of Radiology does not translate into a sudden 5% discharge drop in 1992; and if it does, it is because the hospital's administrative team was "asleep at the switch" and could have taken more aggressive steps between 1986 and 1992 to rectify the potential problem, thus taking it out of the reach of a § 412.92(e)(2)(ii) "circumstance beyond its control" defense.

The Intermediary SCH Volume Adjustment is correct, and should stand.

_____

Henry C. Wessman, Esq.
Senior Board Member