PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2003-D58

PROVIDER –
Hospital Auxilio Mutuo
Hato Rey, Puerto Rico

Provider No. 40-0016

vs.

INTERMEDIARY – Cooperativa de Seguros de Vida de Puerto Rico

DATE OF HEARING -
August 6, 2003

CASE NO. 95-0590

INDEX

ISSUE:

Was the Centers for Medicare & Medicaid Services' denial of the Provider's exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hospital Auxilio Mutuo ("Provider") is a short-term, not-for-profit, 386-bed facility located in Hato Rey, Puerto Rico. The Provider was certified to furnish renal dialysis services in 1980, and performed 41 kidney transplants during its 1993 cost reporting period.[1]

Pursuant to instructions issued by the Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), the Provider requested an exception to its End Stage Renal Disease ("ESRD") prospective payment rate (composite rate). The Provider's request was timely filed on April 28, 1994, in response to the exception process opened by CMS effective November 1, 1993. The basis of the Provider's request was "Atypical Service Intensity" causing the Provider's costs to exceed the prospective rate otherwise in effect.

Cooperativa de Seguros de Vida de Puerto Rico ("Intermediary") reviewed the Provider's request in accordance with program instructions contained in Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2723, and forwarded it to CMS on May 19, 1994. On July 14, 1994, CMS denied the Provider's request, maintaining, in general, that the Provider failed to submit certain documentation in a format required by the program.

On December 28, 1994, the Provider appealed CMS' denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F. R. §§ 405.1835- 405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $577,829.[2]

The Provider was represented by Raul De Jesus Romero, Esq. The Intermediary was represented by Wallace Vazquez Sanabria, Esq.

PROVIDER'S CONTENTIONS:

The Provider contends that its exception request contained adequate cost and statistical data to show that its cost per treatment exceeded Medicare's composite rate due to an atypical patient mix. The Provider argues that even though certain information was not presented in a specific format, CMS could have extracted enough data from its request to justify and approve an exception to Medicare's composite rate.[3]

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[1] Exhibit P-2 at 5 of 15.

[2] Intermediary Position Paper at 1. Provider Position Paper at 1.

[3] Provider Position Paper at 4.

The Provider contends that the Intermediary reviewed the subject request and found it to be in compliance with pertinent manual instructions at HCFA Pub. 15-1 § 2721 and § 2751. Moreover, the Intermediary recommended that CMS approve the composite rate of $145.77 as requested by the Provider. The Provider contends that if the Intermediary had noted any suspected areas of non-compliance it could have immediately amended its request. Also, CMS failed to offer any opportunity for the Provider to file additional data or schedules in specified formats.

The Provider contends that its actual cost per treatment for infacility hemodialysis in 1993 amounted to $140.84. The Provider explains that this amount exceeded CMS' published rate effective November 1, 1993, set at $121.17 per treatment. In addition, the Provider explains that the rate it requested, $145.77 per treatment, represents only a 3.5 percent increase over its 1993 actual costs for infacility hemodialysis and a 24.76 percent increase in treatments. The Provider also explains that its projected cost per treatment for 1994 is fully documented in Exhibit I-8 of its exception request.[4]

The Provider contends that CMS determined its fiscal year 1993 combined cost per treatment to be $126.64, which included its infacility hemodialysis services in addition to its home care program services.[5] The Provider asserts that this same methodology can be used as an alternative approach for projecting a combined cost per treatment for 1994. The Provider asserts that the same cost and treatment percentage increases used to project its infacility hemodialysis cost per treatment to1994, can be applied to its 1993 home care services resulting in a projected 1994 combined cost per treatment of $130.54.[6]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to comply with program instructions at HCFA Pub. 15-1 § 2721.E. Therefore, CMS was unable to adjudicate the Provider's exception request.[7]

The Intermediary explains that Medicare's instructions require each exception request to include a schedule showing the cost per treatment for each component of cost (e.g., salaries, supplies, depreciation) by each mode of dialysis treatment a provider furnishes. In addition, providers must include separate schedules "combining" total outpatient and home maintenance dialysis services, i.e., one schedule addressing a provider's actual combined cost per treatment and a separate schedule addressing its combined budgeted or projected cost per treatment.

Upon review, CMS found that the Provider's request included only a cost per treatment analysis for its infacility hemodialysis services. The Provider's request did not include the required information for home care treatments, even though it is evident from the Provider's 1993 cost report that it furnishes this type of care. Although CMS was able to

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4 Exhibit P-1.
5 Provider Position Paper at 8 at No. 12. Exhibit P-4.
6 Provider Position Paper at 9 at No. 17
7 Intermediary Position Paper at 9 at No. 14.

compute a combined cost per treatment for the Provider from its actual 1993 cost and utilization data, CMS was unable to compute a 1994 combined cost per treatment because the Provider failed to furnish 1994 projections for its home care programs. CMS cited HCFA Pub. 15-1 § 2721.E, which states in part: "the facility must submit a schedule combining total outpatient and home dialysis costs, since the composite rate system is based on a single payment for all outpatient maintenance dialysis treatments (infacility and home)."

Finally, the Intermediary points out that the Provider filed its request just one day before the close of filing deadline. Although the request was timely, the Provider's late filing did not allow time for the Provider to supplement its request once omissions had been identified, regardless of whether or not the omissions were identified by CMS or the Intermediary.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes as follows:

In a letter dated October 1, 1993, the Intermediary advised the Provider that CMS was opening a 6-month period in which ESRD facilities could request an exception to Medicare's composite payment rate for renal dialysis services. This letter specified that the exception request period would begin on November 1, 1993, and end on April 29, 1994. Moreover, the letter explained that exception requests received after the closing date of April 29, 1994, would not be considered timely and would not be subject to CMS review.

On April 28, 1994, one day prior to the close of the exception cycle, the Provider filed an exception request with the Intermediary. The Intermediary reviewed the request and forwarded it to CMS on May 19, 1994, along with its recommendation. In part, the Intermediary concluded that "based on [its] limited review" the Provider's request was in compliance with program requirements, and the payment rate sought by the Provider of $145.77 per treatment appeared well documented, reasonable and necessary.

CMS found that the Provider did not furnish all of the information necessary to adjudicate the request and denied it. Specifically, CMS found that the Provider furnished schedules showing its actual and budgeted total cost per treatment for its infacility outpatient hemodialysis service. The Provider did not, however, furnish schedules showing its actual and budgeted total cost per treatment for its infacility outpatient service combined with its home maintenance dialysis services as required by program instructions at HCFA Pub. 15-1 § 2721. E. Although CMS was able to compute a total combined "actual" cost per treatment for the Provider's 1993 fiscal year, it was unable to compute a budgeted combined total cost per treatment because the Provider's request did not contain projected cost and utilization data for its home care programs.

The Provider argues that all of the information necessary to justify a payment rate greater than Medicare's composite rate is contained within its request and CMS could have extracted this data in order to grant an exception. The Provider argues that had the Intermediary discovered any discrepancies with its request as opposed to acknowledging the request's compliance with program rules, it could have promptly corrected any errors or omissions. And, although the Provider relies upon the Intermediary's recommendation that its request for an exception rate of $145.77 per treatment be granted, as an alternative, it requests that a rate of at least $130.54 per treatment be granted based upon the methodology used by CMS to compute its combined total cost per treatment for 1993.

The Board concludes that CMS' denial of the subject request was proper. Although the Board is not bound by program instructions such as Medicare's Provider Reimbursement Manual, it is compelled to affirm CMS' decision based upon the Provider's failure to document its total combined budgeted cost per treatment pursuant to HCFA Pub. 15-1 §2721. E.

The Board finds it essential for a provider requesting a prospective or forward looking payment rate to furnish accurate budget estimates and utilization trends through the period for which the exception would apply in order to help assure proper program payments. With respect to this matter, the Board finds that 42 C.F.R. § 413.170(f)(6), under the captioned title Procedures for requesting exceptions to payment rates, gives CMS an extremely wide latitude to establish exception request data requirements. In part, the regulations state "[i]f requesting an exception to its payment rate, a facility must submit . . . whatever statistics, data, and budgetary projections are determined by HCFA to be needed to determine if the exception is approvable." Upon this authority, CMS adopted explicit requirements including those at HCFA Pub. 15-1 § 2721. E. It is undisputed that the Provider failed to submit its forecasted cost and utilization trends for its home care services. This information is essential for calculating a payment rate that would be applied to future periods.

The Board disagrees with the Provider's argument that CMS could have extracted sufficient data from its request to substantiate an exception to Medicare's composite rate. As noted, forecasted cost and utilization data must be present for the Provider's home dialysis services and that information is not available. Even though the Provider's infacility outpatient cost per treatment, both actual and projected, may exceed Medicare's composite rate, when that information is combined with the Provider's home dialysis costs per treatment, the Provider's "total" cost per treatment could drop below Medicare's composite rate. This is evident from CMS' analysis of the Provider's 1993 costs, where the Provider's 1993 infacility outpatient cost per treatment of $140.84 yielded a total cost per treatment of $126.12 when combined with the Provider's home dialysis cost and utilization data. The Board also finds that CMS is not responsible for justifying the relief sought by the Provider. Rather, 42 C.F.R. 413.170(f)(5) clearly makes the Provider responsible for substantiating its exception request, as follows:

> [t]he facility is responsible for demonstrating to HCFA's satisfaction that the requirements of this section . . . , are fully met. 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. . . . The burden of proof is not on HCFA to show . . . that the facility's costs are not allowable.

42 C.F.R. 413.170(f)(5).

The Board also disagrees with the Provider's argument that it could have cured any omissions in its request had the Intermediary identified them rather than finding its request in compliance with program's rules. Regulations at 42 C.F.R. § 413.170(f)(4) require exception requests to be submitted within 180 days after a facility is notified of its prospective rate. In this case, the Provider submitted its request just one day prior to the end of the 180-day exception cycle, allowing no time for errors or omissions to be corrected even if the Intermediary would have found them. Moreover, the Board finds that the Provider's submission, i.e., late in the exception cycle, also allowed no time for errors or omissions to be corrected once they were identified by CMS.

Finally, the Board acknowledges but disagrees with the Provider's argument that the methodology used by CMS to determine its 1993 total combined cost per treatment can be used to determine and effectuate an exception payment rate of $130.54. The Board finds that the controlling regulations and manual instructions do not consider alternative computations and they are explicit with respect to timeliness, required information and burden of proof.

DECISION AND ORDER:

CMS' denial of the Provider's request for an exception to Medicare's ESRD prospective payment rate is proper. CMS' denial is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, CPA

DATE: September 24, 2003

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman