PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D6

PROVIDER –
Alpena Dialysis Services
Alpena, Michigan

Provider No. 23-2553

vs.

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

DATE OF HEARING -
January 22, 2003

CASE NO. 01-0742

INDEX

ISSUE:

Did the Centers for Medicare and Medicaid Services ("CMS")[1] correctly deny Alpena Dialysis Services' request for an exception to the end stage renal disease ("ESRD") composite rate?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Alpena Dialysis Services ("Provider") is an independent, free-standing dialysis facility located in Alpena, Michigan. The facility is jointly owned by Northern Michigan Hospital and Alpena General Hospital. Pursuant to the provisions of §1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq., hospital-based and free-standing ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system. Under this system, a provider of dialysis services receives a prospectively determined payment for each dialysis treatment that it furnishes. An ESRD facility must accept the composite prospective payment rate established by CMS as payment in full for covered outpatient dialysis. During certain periods of time generally referred to as exception windows, an ESRD provider may request an exception to its composite rate in accordance with the procedures established under 42 C.F.R. §413.180. Such an exception window was opened by HCFA commencing on March 1, 2000. The Provider submitted a timely exception request to the composite rate for maintenance dialysis services ($123.96 per treatment) to United Government Services, LLC – WI ("Intermediary").[2] The Provider sought an exception in the amount of $26.65 per treatment on the basis of atypical service intensity and additional nursing service and administrative costs. Following a review of the exception request, the Intermediary forwarded the request to HCFA and recommended approval of a base hemodialysis rate of $150.61.[3]

HCFA denied the Provider's exception request based on its determination that the Provider failed to justify any increased cost due to atypical service intensity.[4] The Provider timely appealed HCFA's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §413.194 and has met the jurisdictional requirements set forth in 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Jeffrey A. Lovitky, Attorney at Law. The Intermediary's representative was Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA properly denied the Provider's exception request pursuant to the governing regulation at 42 C.F.R. §413.184. Under the regulation, a provider must demonstrate that its per treatment costs in excess of its composite rate are

---

[1] CMS was known as the Health Care Financing Administration ("HCFA") at the time denial actions were taken. This decision will refer to the name of the agency as CMS unless otherwise required by context.

[2] See Provider's Exhibit P-1 to Provider's Final Position Paper.

[3] See Provider's Exhibit P-2 to Provider's Final Position Paper.

[4] See Provider's Exhibit P-3 to Provider's Final Position Paper.

reasonable, allowable and directly attributable to the servicing of an atypical patient mix. Since the Provider did not substantiate an atypical patient mix nor demonstrate the provision of atypical nursing and administrative services, it failed to meet the specific exception requirements under 42 C.F.R. §413.184. The Intermediary states that its position is best reflected in HCFA's denial letter and supporting workpapers.[5]
Based on its review of the Provider's documentation submitted in support of its request for relief from the composite payment rate, HCFA's denial letter included the following determinations:

> Atypical Patient Mix
>
> Normally a finding that a provider treats an atypical patient mix as set forth in 42 C.F.R. §413.184 is required before evaluating the propriety of a facility's excess per treatment costs to ensure they are reasonable, allowable, and directly attributable to the servicing of an atypical patient mix as specified in 42 C.F.R. §413.182. In the current appeal of the Provider's composite rate, such a finding is unnecessary because sufficient basis exists for a denial of [the Provider's] exception request on other grounds. The basis for that denial follows.
>
> Cost Justification
>
> On page 6 of the narrative of its request for relief, the Provider states that its incurred FYE 12/31/99 labor costs were $52.16 per treatment, $12.16 in excess of the $40.00 reflected in the composite rate. The Provider computed this amount based on $186,273 in salaries for hemodialysis services and 3571 hemodialysis treatments. However, the composite payment rate applies to patients on hemodialysis and home dialysis in accordance with sections 2702 and 2725.1.C of HCFA Pub. 15-1. When the Provider's home continuous ambulatory peritoneal dialysis ("CAPD") patients are included, [the Provider's] FYE 12/31/99 labor costs per treatment are $44.75, and projected to be $46.09 in FYE 12/31/00. See Enclosure 1. We point out that the Provider, in filing its cost reports, did not separately identify employee health and welfare costs. Therefore, its labor costs include employee benefits. Section 2723.3 of HCFA Pub.15-1 reveals that salaries and employee benefits together comprise $47.00 of the composite rate. As the Provider's FYE 12/31/99 incurred labor and forecasted 12/31/00 labor costs are less than this amount, [the Provider] is not entitled to an adjustment to its composite rate for atypical labor expense, regardless of whether or not its patient mix is atypical.

---

[5] See Intermediary's Exhibit I-3.

We also noted the Provider's argument that it furnishes an atypical number of nursing hours per treatment. Enclosure 2 based on Worksheets B-1 and C from the Provider's FYE 12/31/98, 12/31/99, and projected FYE 12/31/00 cost reports reveals that the Provider's average number of direct patient care hours per treatment was 4.19 in FYE 12/31/98, 2.70 in FYE 12/31/99, and forecasted to be 2.78 in FYE 12/31/00. A provider with an atypical patient mix based on data for ESRD outpatients treated during its most recent cost reporting period must also demonstrate that it furnishes atypical nursing services based on the number of direct patient care hours per treatment in accordance with section 2725.1 of HCFA Pub. 15-1.

National audited data for 1988 and 1991, the latest available, show that average direct patient care hours, excluding social workers and dieticians, were 3.00 hours per treatment. Thus, even if the Provider's patient mix was found to be atypical, its nursing hours per treatment were not atypical. Accordingly, even with an atypical patient mix, the Provider's exception request must still be denied, as [the Provider] has not shown that it furnishes atypical nursing services,

Administrative and General Expense

The Provider reasons that because it believes it has justified atypical labor expense due to the provision of atypical services, then it should automatically be entitled to an exception allowance for atypical administrative and general ("A&G") expense because of higher accumulated costs, the prescribed cost finding statistic for allocation of A&G expense. On page 6 of its exception request, [the Provider] states as follows in pertinent part:

> Administrative and General (A&G) costs are allocated to the renal cost center based on accumulated costs for the various modes of dialysis based on the accumulated direct costs for each mode. Thus, as the direct cost of rendering a dialysis treatment is increased with regards to labor, supplies, capital costs and employee benefits the A&G cost per treatment is increased proportionately. [The Provider] has calculated this cost which is summarized on a per treatment basis below based on our FY 1999 maintenance hemodialysis cost per treatment. . . .

The Provider's labor costs are not atypical, and [the Provider] has not demonstrated that it furnishes atypical nursing services. Therefore, its argument with respect to entitlement to incremental A&G expense based on atypical nursing costs is moot. However, we wish to respond to the Provider's argument.

A&G expenses are allocated on the basis of accumulated costs. Therefore, if the direct costs of a facility are higher, it follows that the A&G cost allocated to all treatment modalities will also be higher. However, that does not mean that the higher allocated costs are specifically and directly attributable to the atypical patients. The accounting protocols used for cost reporting may or may not be appropriate in identifying costs directly attributable to atypical patients. For example, if a provider incurred additional nursing costs (overtime hours) because of treating atypical patients, there might be no additional costs incurred at all with regard to data processing, a home office, employee health insurance, purchasing, or telephones. True, the additional direct nursing costs would result in an increased allocation of those overhead costs, but it does not necessarily follow that the increased A&G allocation represents costs that are attributable to the atypical patients. Costs do not become directly attributable merely because of the use of a particular statistic as an allocation basis. Medicare regulation 42 C.F.R. §413.182 states as follows in pertinent part:

> HCFA may approve exceptions…if the facility demonstrates…that its per treatment costs in excess of its payment rate are directly attributable to…
>
> (a) Atypical service intensity (patient mix)…
>
> Emphasis added.

The requirement that overhead costs be directly attributable to the special needs of atypical patients for purposes of consideration under the atypical services exception criteria is further set forth in section 2725.1B.4 of HCFA Pub. 15-1 which states as follows:

> 4. Overhead Costs –There are infrequent instances, (e.g., hepatitis) when an isolated area is required and when higher overhead costs may be justifiable. For these costs to be considered under this exception criteria (sic),

> documentation must be submitted that identifies the basis of higher overhead costs, the specific cost components to be impacted, and the incremental per treatment costs. General statements regarding a facility's higher overhead costs are not acceptable in meeting the criteria.

We reject the Provider's argument that it should be entitled to an exception allowance for higher allocated A&G costs simply because of a proportional increase in those costs solely due to atypical labor costs. Moreover, the Provider's labor costs are not atypical. Because the Provider has not shown that it furnishes atypical nursing services, it has not justified that its higher overhead costs are directly attributable to the special needs of atypical patients in accordance with 42 C.F.R. §§413.182, 413.184, and section 2725.1B.4 of HCFA Pub. 15-1.

Worksheet S-1 of the Provider's FYE 12/31/99 cost report reveals that [the Provider] has 10 renal dialysis machines regularly available for use and operating 6 days per week or 312 days per year. The number of days dialysis is furnished, number of machines, and number of treatments furnished per day are entirely within a provider's discretion. The Provider's maximum operating capacity is 9360 treatments (10 X 3 treatments X 312 days). Based on the reported number of 3571 hemodialysis treatments in FYE 12/31/99, adjusted to exclude 161 inpatient treatments as reported in Exhibit 18, [the Provider's] outpatient dialysis utilization rate was:

$$\frac{3571 \text{ minus } 161}{9360} = 36.4\%$$

We believe the Provider's high overhead costs per treatment are in large part due to its significant excess idle capacity of 63.6%. They are particularly disturbing because overhead costs are not directly related to patient care.

Other issues

The Provider's cost reports reflect a home CAPD program, but no CAPD training expenses. Exhibit 26 references a system which the Provider employs to allocate salaries between the training and home program. If the Provider is properly certified to furnish a home CAPD program, then its training expenses

must be reflected on the cost report for a proper allocation of necessary overhead and reimbursement in accordance with section 2707 of HCFA Pub. 15-1.

In its Exhibit 18, [the Provider] reported 161 inpatients dialysis treatments in FYE 12/31/99, and projected 192 in FYE 12/31/00, and 223 in FYE 12/31/01. The Provider's FYE 12/31/99 inpatient treatments comprised 4.5% of its total hemodialysis treatments. Renal related services to hospital inpatients are reimbursed under the hospital prospective payment system, not the ESRD composite rate. However, the Provider's FYE 12/31/99 cost report neither reveals a Worksheet A-2 adjustment excluding the direct and indirect costs for inpatient renal treatments, nor the establishment of a non-reimbursable cost center for the exclusion of costs associated with providing those treatments. Given the number of inpatient treatments, and generally higher allocation of salary and supply expense to inpatient treatments compared to outpatient treatments, we believe the establishment of a non-reimbursable cost center rather than a Worksheet A-2 offset is the appropriate cost reporting treatment for [the Provider's] inpatient dialysis treatments furnished under arrangements.

On page 5 of its exception request the Provider stated that it was not seeking atypical supply expense because its costs did not exceed the amount reflected in the composite rate. [The Provider's] FYE 12/31/99 supply costs per treatment were $33.42, and projected to increase to $34.43 in FYE 12/31/00. See Enclosure 1. The Provider's FYE 12/31/99 supply expense exceeded the amount included in the composite rate by $.42, after including home CAPD supply costs. Although the Provider did not request an exception for atypical supply expense, and we are not rendering a determination on [the Provider's] claim of an atypical patient mix, an atypical supply cost exception request would be denied because of the Provider's failure to properly report CAPD training and non-reimbursable inpatient treatment costs. Given this commingling of expenses, the Provider's outpatient supply expenses are distorted, and may not be used for purposes of considering an adjustment to its composite rate….

Conclusion

The Provider's labor costs per treatment, including employee benefits, do not exceed the $47.00 amount reflected in the composite rate, as set forth in section 2723.3.D. of HCFA Pub. 15-1. Moreover, the Provider's nursing hours per treatment are

> not atypical. Therefore, the Provider has not demonstrated the provisions of atypical nursing services. Accordingly, its request for an atypical services exception covering additional nursing service cost and incremental A&G expense is denied in its entirely. A HCFA finding that the Provider treats an atypical patient mix is not necessary in this case….

At the hearing before the Board, the Intermediary's witness was the CMS Health Insurance Specialist who was assigned the exception request at issue and was the author of the denial letter. This witness testified that the primary basis for denying the Provider's request was that the Provider did not exceed the national average of 3.0 hours per treatment.[6] As to the source of the 3.0 hours per treatment standard, the witness testified that he discussed this matter with his technical advisor and another analyst who had firsthand knowledge of the data used and the methodology employed. It was his testimony that the data was primarily obtained from audited cost reports of freestanding ESRD facilities for fiscal years 1988 and 1989. The data was selected based upon a stratified random sample that was statistically representative of freestanding facilities in the United States.[7]

In support of the 3.0 hours per treatment standard, the Intermediary's witness referred to various governmental reports (See Intermediary's Exhibits I-4, I-5 and I-6) to demonstrate that the contemporary standard for the duration of a dialysis session had increased to 3.5 hours. Based on his analysis of these reports, it was his conclusion that the average dialysis time of 3.5 hours was a more realistic standard, and that the application of the 3.0 hours threshold in denying the Provider's exception request was a very generous and liberal standard.[8]

In summary, it is the Intermediary's conclusion that the Provider has not met its burden of proof that it is providing atypical services. Accordingly, the Board should uphold CMS' denial of the Provider's exception request.

PROVIDER'S CONTENTIONS:

The Provider contends that it satisfied the atypical service intensity criteria set forth in 42 C.F.R. §413.184 and §2725.1 of the Provider Reimbursement Manual ("CMS Pub. 15-1"). The applicable regulations state in pertinent part:

> 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.

---

[6] Tr. at 165-166, 203, 278-279.
[7] Tr. at 168-169.
[8] Tr. at 183-193.

42 C.F.R. §413.184(a)(1)

The Provider argues that its exception request provided solid evidence that its level of patient acuity was higher than the national average. In support of this position, the Provider refers to its exception request which delineated the following variations between the Provider's patient population and the national average:

- 22.2 percent of the Provider's patients are 75 years and older as opposed to a national average of 14.5 percent.
- 36 percent of the Provider's regular patients are diabetic as compared to a national average of 33 percent.

The Provider further points out that its exclusion of transient patients in formulating its exception request was justified under the unique circumstances of this case.[9] The Provider is located in a nationally renowned resort area which attracts a large percentage of transient patients who are typically present in the local area for only a brief period of time. Since these patients receive a limited number of dialysis treatments, it is appropriate to exclude this transient population when attempting to evaluate the overall nature of the Provider's patient population. Moreover, these patients are counted in HCFA's database only at the location at which they are regularly dialyzed, and the inclusion of the transient patients in the Provider's data sets would result in the counting of such patients more than once. Based upon the above-stated factors, the Provider believes it has clearly satisfied the criteria for atypical service intensity.

The Provider contends that the governing regulation at 42 C.F.R. § 413.184 required HCFA to make a determination as to whether its patient mix was atypical. However, HCFA's denial letter did not include such a determination. Instead, HCFA asserted that no such determination was required because the Provider's costs did not exceed the national norms. While the regulation at 42 C.F.R. §413.184(a)(2) requires a facility to demonstrate that its costs are "prudent and reasonable when compared to those of facilities with a similar patient mix," there is nothing in the regulation that makes atypical patient mix relief contingent upon establishing higher costs than some hypothetical average. The application of such a criterion would penalize providers who efficiently control their costs and reward less efficient providers with higher costs. The regulatory criteria for obtaining exception relief relates solely to patient mix, and HCFA erred in not making a determination as to whether the Provider's patient mix was atypical.

The Provider also contends that it furnished ample cost justification in support of its exception request. The manual provision at CMS Pub. 15-1 §2725.1 authorizes an exception on the basis of significantly increased nursing hours per treatment. In its denial letter, HCFA determined that the Provider's average direct patient care hours for the fiscal year ended ("FYE") December 31, 1998 were 4.19 per treatment; 2.70 per treatment for the FYE December 31, 1999, and were forecasted to be 2.78 for the FYE December 31, 2000. HCFA's denial letter stated in pertinent part the following:

---

[9] The Provider defines a transient patient as a patient who requires 11 or less dialysis treatments per year.

> National audited data for 1988 and 1991, the latest available, show that average direct patient care hours, excluding social workers and dieticians, were 3.00 hours per treatment. Thus, not only is the Provider's patient mix not atypical, its nursing hours per treatment were not atypical.

In response to its discovery request, the Provider obtained copies of the "national audited data" which HCFA relied upon in calculating the 3.0 hours per treatment standard.[10] Using the identical data relied upon by HCFA, the Provider's consultant calculated average direct patient care hours, including social workers and dieticians, as equaling 3.07 hours per treatment. If social workers and dieticians are excluded, average direct patient care hours equaled 2.86 hours per treatment.[11] Contrary to the terms of HCFA's denial letter, the Provider contends there is no 3.0 hours per treatment standard. Moreover, the Intermediary's witness admitted during his testimony before the Board that he was unable to arrive at the 3.0 hours per treatment figure based upon the data available.[12]

The Provider points out that there are other deficiencies with the data used by HCFA in calculating its average hours per treatment standard. For example, it appears that the sample used to develop the 3.0 hours per treatment figure excluded home-based or peritoneal patients. Since home patients generally require less nursing assistance, the exclusion of such patients from the sample would inflate the average time per treatment, thereby making it more difficult to qualify for an exception.[13] The Provider also notes that the sample was based upon a survey of 63 out of a total of 1,819 ESRD facilities (3.5 percent of the aggregate). The Provider's consultant testified that the sample was not large enough to ensure its statistical reliability,[14] and the Intermediary's witness testified that he was unable to form any opinion as to the size of the sample.[15] Other deficiencies in the HCFA sample noted by the Provider included the skewed geographic distribution, no breakdown between rural and urban facilities, and the age of the data, as it was derived from fiscal years 1988 and 1989.

The Provider contends that HCFA's failure to produce any evidence supporting the statistical reliability of its study is of overriding importance. HCFA produced no documentation as to the method of randomization of the facilities selected, justification for the sample size, or how it was determined that the sample size was statistically reliable. Without such documentation, the Provider insists that there is no way to audit the study or verify its results. Based on the above noted deficiencies, the Provider concludes that there is no statistical support for HCFA's 3.0 hours per treatment standard.

---

[10] See Provider's Exhibit P-15.
[11] See Provider's Exhibit P-27.
[12] Tr. at 176-178.
[13] Tr. at 70-74, 253-255
[14] Tr. at 76-77.
[15] Tr. at 237-240.

HCFA also denied the exception request on the basis that the Provider's combined salary and employee benefits were slightly less than the national average of $47.00 per treatment. Based on the information furnished by CMS in response to the Board's subpoena,[16] the Provider argues that there is no support for the average cost per treatment figures contained in CMS Pub. 15-1 §2723.3. In its response, CMS believed that 1983 and 1984 data were used in developing the cost per treatment figures, but conceded that the data no longer existed. With regard to the hours per treatment standard, no documentation was produced as to whether or how a randomized sample of facilities was selected, or how the size of the sample selected was justified. Accordingly, it is not possible to place any credence in the cost per treatment figures contained in the manual. Moreover, such data does not take into consideration the enormous increases in productivity over the past twenty years.

In denying the Provider's request for overhead exception relief, HCFA stated: "Because the Provider has not shown that it furnishes atypical nursing services, it has not justified that its higher overhead costs are directly attributable to the special needs of atypical patients . . ." The Provider argues that the test applied by HCFA misconstrues the requirement as it pertains to indirect expenses. Such costs increase proportionately as the direct cost of rendering dialysis treatment increases. As to HCFA's inference that higher costs were due to the Provider's idle capacity, the Provider points out that it must maintain sufficient dialysis capacity to accommodate the surge requirements of tourist periods. Therefore, any idle capacity is clearly justified by the unique and particular circumstances attributable to the Provider.

In summary, it is the Provider's conclusion that HCFA improperly used overall national averages as the yardstick to measure its costs. The regulation at 42 C.F.R. §413.184(a)(2) states the following:

> (2) The facility must demonstrate clearly that these services, procedures, or supplies and its per treatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix.

42 C.F.R. §413.184(a)(2)

The Provider argues that the record is devoid of any indication that HCFA made any such comparison in adjudicating its exception request. Instead, HCFA used an overall average of 3.0 hours per treatment and a cost for salary and benefits of $47 per treatment as the bases for denying Provider's request. Neither value is representative of other facilities with "similar patient mix" to the Provider as required by the applicable regulation. Since the Provider fully justified its claim based upon atypical service intensity and submitted ample justification of its cost, the Board should grant its exception request in its entirety.

---

[16] See Provider's Exhibits P-4 and P-6.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and Program instructions, the parties' contentions, facts and evidence presented, finds and concludes as follows:

The Board finds that CMS properly denied the Provider's request for an exception to the ESRD composite rate because the Provider failed to meet its burden of proving that it rendered atypical services to its ESRD patients as required under the controlling regulatory provisions of 42 C.F.R. §413.184. In order to qualify for an exception based on atypical service intensity, the regulation states:

> 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….

42 C.F.R. §413.184

The Provider sought an exception to the composite rate for atypical nursing and administrative and general costs based on its contention that it served an atypically more acute patient population than the national norms. Pursuant to the regulation at 42 C.F.R. §413.182, CMS may approve such an exception request if the facility demonstrates by convincing objective evidence that: (1) its total per treatment costs are reasonable and allowable under the relevant cost reimbursement principles, and (2) its per treatment costs in excess of its payment rate are directly attributable to atypical service intensity. Accordingly, the Provider is responsible for justifying and demonstrating to CMS' satisfaction that the requirements and criteria for an exception request are met in full. It is the Board's conclusion that the Provider has not furnished evidence to support its atypical services exception request or that its excess costs were directly attributable to this factor.

In support of its argument that its facility had an atypical patient mix, the Provider dealt only with its composition of aged and diabetic patients. While the Provider's patient population did reflect a higher percentage than the national averages in these categories, the Board notes that the variations did not reflect a substantial deviation from the national norms.[17] Moreover, the Provider did not take into consideration other factors in its patient mix analysis which should have been addressed in its exception request (i.e., mortality rate, length of stay for patients requiring inpatient admission, average age of patient population, and individual patient diagnosis). Given the fact that the Provider's own patient analysis did not demonstrate a significant deviation from the national averages, the Board is not able to make a clear determination that the Provider had an atypical patient mix which justified the incurrence of additional costs per treatment.

[17] The Board also took into account the exclusion of transient patients which the Provider believes is more appropriate.

Despite the Board's finding that the Provider failed to meet the threshold requirement of patient atypicality, the Board nevertheless analyzed the Provider's cost data. The primary argument presented by the Provider in support of its exception request based on atypical service intensity was that it furnished an atypical number of nursing hours per treatment. Based upon its analysis of the data presented in the Provider's exception request, CMS determined that the Provider's average number of direct patient care hours per treatment was less than the national average of 3.0 hours per treatment.

While the Provider did not dispute CMS' recalculation of the number of direct patient care hours per treatment for its facility, the Provider did challenge the validity of the standard applied by CMS in determining that the Provider had not shown that it furnished atypical nursing services. Although the Provider cited various deficiencies in the data and methodology employed by HCFA in establishing the 3.0 hours per treatment standard, the Board notes that the Provider did not present alternative data which would support the use of another standard. By contrast, CMS did present additional governmental reports which demonstrated that a more realistic contemporary standard for the duration of a dialysis session may have increased to 3.5 hours.[18] Accordingly, the Board concludes that CMS applied an appropriate standard to measure the Provider's atypical service intensity and properly denied the Provider's exception request that was based upon that criterion.

The Board also finds that because the Provider has not demonstrated that it had an atypical patient mix or that it furnished atypical nursing services, the Provider has not shown that is higher overhead costs were directly attributable to the special needs of atypical patients. The argument that the Provider should be entitled to an exception allowance for higher allocated administrative and general costs because of a proportional increase in those costs due solely to atypical labor costs is therefore rejected.

The Board also concurs with CMS' contention that the Provider's higher overhead costs per treatment were in large part due to its significant excess idle capacity (63.6%).

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. §413.184. CMS' denial is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire

---

[18] See Intermediary's Exhibits:
I-4 - Report to Congress: Medicare Payment Policy
I-5 - HCFA 2000 Annual Report ESRD Clinical Performance Measures Project
I-6 - CMS 2001 Annual Report ESRD Clinical Performance Measures Project

Elaine Crews Powell, C.P.A.

DATE: December 22, 2003

FOR THE BOARD

Suzanne Cochran
Chairman