# PROVIDER REIMBURSEMENT REVIEW BOARD
# DECISION

ON THE RECORD
2005-D60

**PROVIDER -**
Mary Imogene Bassett Hospital-Oneonta
Satellite Dialysis Facility
Oneonta, New York

Provider No.: 33-3531

**vs.**

**INTERMEDIARY -**
BlueCross BlueShield Association/
Empire Medicare Services

**DATE OF HEARING -**
May 2, 2005

ESRD Period Ended -
July 1, 2001

**CASE NO.:** 02-1126

**INDEX**

ISSUE:

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system.[1] Under this system, a provider of dialysis services receives a prospectively determined payment for each dialysis treatment that it furnishes. An ESRD facility must accept the composite prospective payment rate established by CMS as payment in full for covered outpatient dialysis unless it qualifies for one of the exceptions in accordance with the procedures established under 42 C.F.R. §413.180 et seq.

The Mary Imogene Bassett Hospital (MIBH or Provider) is located in Cooperstown, New York and provides renal dialysis services. In 1999, it opened the Mary Imogene Bassett Hospital-Oneonta Satellite Dialysis Facility (MIBHOSDF) in Oneonta, New York. MIBHOSDF applied to Empire Medicare Services, (Intermediary), for an exception to the ESRD composite rate on the grounds that it qualified as an Isolated Essential Facility (IEF) as provided in 42 C.F.R. §413.186.[2] The Provider requested a rate of $139.48 instead of the then current rate of $122.82.[3] The Intermediary recommended to CMS that the exception request be granted.[4]

CMS denied the exception request[5] and denied reconsideration of its decision.[6] The Provider then filed a timely request for a hearing with the Provider Reimbursement

[1] Section 1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq.,
[2] Intermediary Exhibit 1.
[3] See July 12, 2005 joint stipulation. While the Provider, in its exception request, stated that the current rate was 122.82, the current rate was actually $126.25.
[4] Intermediary Exhibit 7.
[5] Intermediary Exhibit 2.
[6] Intermediary Exhibit 5.

Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841.[7]

INTERMEDIARY'S CONTENTIONS:

The CMS denial explained that "when CMS processes an exception request from a hospital-based facility that has one or more satellite facilities associated with it, CMS reviews the costs and circumstances of the **entire** facility including all satellites, to see if the exception criteria are met." Although MIBH originally met the IEF exception criteria, CMS asserted that MIBH's surrounding "geographical" area has changed. The existence of MIBH and thirteen other ESRD facilities in MIBHOSDF's geographical area disqualifies MIBHOSDF from qualifying for an IEF exception. CMS found the application deficient in that MIBHOSDF provided no documentation regarding whether the seven facilities which were certified after the closing of the last ESRD exception window could accommodate MIBHOSDF's patients should MIBHOSDF close or cease to provide outpatient ESRD services.

CMS also noted that over 50% of MIBHOSDF's patients drive themselves, that MIBH and MIBHOSDF are only 24 miles apart and are connected by Interstate 88, and that some MISHOSDF's patients live closer to MIBH than MIBHOSDF. Additionally, 16% of the same patients that had previously received dialysis services at MIBH were now receiving those services at MIBHOSDF.

PROVIDER'S CONTENTIONS:

The Provider contends that MIBHOSDF should qualify for an IEF exception as the scarcity of major highways, lack of substantial public transportation, and severe weather make travel difficult. MIBHOSDF is essential because a substantial number of its patients cannot obtain renal dialysis services elsewhere without additional hardship. The travel time between MIBH and MIBHOSDF is 53 minutes, and less than five of the twenty-four miles between the facilities is interstate highway. Also, because the Provider Reimbursement Manual (P.R.M.) at §2721A supports treating MIBH and MIBHOSDF as one entity, the Provider argues that CMS erred in using MIBH's presence as the primary factor in its determination that MIBHOSDF is not isolated.

Moreover, the additional facilities considered by CMS as being able to accomodate MIBHOSDF's patients were outside of CMS' own fifty mile radius "rule of thumb."[8] CMS not only denied the Provider's exception request based upon the presence of

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[7] Intermediary Exhibit 3.

[8] See Moses Taylor Hosp. V BCBSA/BCBS of W. Penn, PRRB Dec. No. 93-D-47 (June 17, 1993). The Board, in that decision, in its summary of the contentions, noted that the Intermediary explained that CMS used a fifty mile radius rule as a "guideline" as opposed to a "rule" when deciding whether a facility is isolated.

In the present case, the Provider contends that "although the rule of thumb is not, of course, a bright line rule, all of the facilities CMS considered were outside of this radius and the rationale behind the rule of thumb applies with greater force to an area such as upstate New York, where winter travel is exceedingly difficult."

facilities as far as 86.7 miles from MIBHOSDF, but also without any information as to whether those facilities were capable of providing the necessary services to MIBHOSDF's patients. Only 39.6% of MISHOSDF's patients drive as opposed to CMS' claim that 50% drive. Also, as of the time MIBHOSDF filed its exception request, the average age of its patients was 66, and 77% were more that 55 years old.[9]

The Provider notes that CMS' denial did not address whether MIBHOSDF's excess costs were justifiable, reasonable and specifically related to the IEF criteria. However, the Provider contends that it substantiated in its exception request that it had satisfied this requirement.[10]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, and the parties' contentions, concludes that the Provider qualifies for an IEF exception to the ESRD composite payment rate. The Board also finds that the Provider's excess costs are justifiable, reasonable, and specifically related to the IEF criteria.

The regulation at 42 C.F.R. §413.182 establishes that, to qualify for an exception to the prospective payment rate, a provider must demonstrate that its costs in excess of the payment rate are "directly attributable" to the criteria under which it seeks to qualify (in this case, "isolated and essential"), and that its per-treatment costs are reasonable and allowable under cost reimbursement principles. Additionally, 42 C.F.R. §413.180(f) generally addresses the documentation providers must submit with an exception request, while §413.186 outlines the additional documentation needed to qualify under the specific IEF exception criteria.

Likewise, the P.R.M. at Sections 2720 through 2725, provides general guidance regarding the exception request process, while Section 2725.3 provides detailed instructions regarding the specific IEF exception. Also, relevant to this case, P.R.M. §2721 states:

> Although satellite facilities are separate facilities and receive a separate provider number for certification purposes, they are still considered to be part of the hospital complex. Their costs flow through the hospital and are reported on the hospital's cost report. Therefore, when CMS processes an exception request from a hospital–based facility that has one or more satellite facilities associated with it, CMS reviews the costs and circumstances of the entire facility, including all satellites, to see if the exception criteria are met.

The Board agrees with the Provider's characterization that the prospective exception request requirement for hospital satellites is "unclear."[11] Intermediaries require that

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[9] Provider Exhibit 1 at p. 4 of Exception Request; Provider Exhibit 1, Sub-Tab 3.
[10] Provider Exhibit 1 at pp. 5-11 of Exception Request; Provider Exhibit 1, Sub Tabs 6-16.
[11] Provider Exhibit 1 at p.1 of Exception Request.

hospital satellite costs be combined with the main renal program on the Worksheet I schedules of the Medicare cost report, yet CMS reviews exception requests for satellites based upon segregated satellite data. Moreover, CMS evaluates the overall losses for both the combined hospital program and the satellite, and if losses at the satellite offset gains in the combined program, the satellite will not receive an exception. Finally, the controlling law, regulation, and policy do not explicitly state whether satellite facilities should be compared to the hospital-based facilities for purposes of receiving an exception.

In this case, the Board finds it illogical to compare MIBH to MIBHOSDF. MIBHOSDF opened to better serve patients who reside deep within an extremely rural area. When MIBHOSDF was created, MIBH was at capacity and had an approved exception rate based on the IEF criteria. Rather than expand the MIBH facility itself, MIBHOSDF opened in a location where it could serve a substantial number of local patients.[12] Accordingly, in this case, the analysis of whether MIBHOSDF qualifies for an exception should be based upon evaluating the nearest non-related facilities (the closest of which is 53.7 miles away). Given the rural roads and harsh weather conditions within this geographic area, it would be unreasonable for the patients to bear the time and expense to use the facilities upon which CMS based its denial.[13] Additionally, it was unforeseeable that CMS would base its analysis upon the presence of facilities as far as 86.7 miles away.[14]

Finally, the Board finds that the Intermediary's determination in its favorable recommendation to CMS that MIBHOSDF's excess costs are justifiable, reasonable, and specifically related to the IEF criteria is supported by the record.[15]

DECISION AND ORDER:

CMS' determination that the Provider is not an IEF and that its costs are not allowable was improper. CMS's denial of the exception request is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

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[12] Provider Exhibit 1, Sub-Tab 5. The Board also notes that even if it were proper to compare MIBHOSDF to MIBH, MIBHOSDF would still qualify for an IEF exception on both the foundations that MIBH was operating at capacity, as well as the existence of the area's rural roadways and severe winter weather.

[13] The Board finds that contrary to the Intermediary's assertion that over 50% of the MIBHOSF patients drive themselves, only 39% of patients drive themselves. See Provider Exhibit 1, Sub-Tab 3.

[14] See Intermediary Exhibit 2; Provider brief at p. 7; Provider Exhibit 1 Sub-Tab 2.

[15] The Board also notes that the Intermediary itself, during its initial review of the Provider's exception request, determined that the costs per treatment were reasonable. See Provider Supplemental Exhibit 11 at page 6; infra note 4.

DATE: August 31, 2005

FOR THE BOARD:

Suzanne Cochran
Chairperson