PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D11

PROVIDER -
St. Joseph Hospital
Orange, California

Provider No.: 05-0069

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
July 13, 2004

Exception Window Beginning -
January 1, 2001

CASE NO.: 02-0812

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 payment due a provider of dialysis services furnished to patients with 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.

St. Joseph Hospital of Orange (Provider) is an acute care hospital located in Orange, California. The Provider applied to Mutual of Omaha (Intermediary) for an exception to the ESRD composite rate on the grounds that its salary and benefit costs exceed national guidelines due to its atypical patient mix. The Provider sought an additional $45.33 per treatment (comprised of $36.22 for nurse salaries and $9.11 for the related fringe benefits) over the allowed $126.36.[2]

The Intermediary recommended to CMS that the exception request be denied, because the Provider failed to provide a breakdown of what each employee was paid.[3] CMS denied the exception request.[4] The Provider then filed a timely request for a hearing with the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

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[1] Section 1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq.,

[2] See Provider's Exception Request, p.34.

[3] Provider Exhibit 1

[4] Provider Exhibit 2.

INTERMEDIARY'S CONTENTIONS:

CMS, in its exception denial, contended that although the Provider had a higher than average percentage of patients under the age of twenty-four, other patient characteristics did not indicate that the Provider was treating an atypical patient mix overall. Also, the Provider submitted conflicting data regarding its number of patients. Additionally, noting that 42.9 percent of the Provider's patients under 18 years old dialyze at home, CMS explained that home dialysis patients are typically healthier than in-facility patients. Moreover, the Provider submitted no time studies or other documentation to substantiate the estimated additional nursing time required to treat the facility's patients in accordance with Provider Reimbursement Manual (P.R.M) §2313. CMS also noted that, in accordance with 42 C.F.R. §413.184(b), a facility requesting an exception must submit a listing of all outpatient dialysis patients (including all home patients) treated during the most recently completed fiscal or calendar year specifying various patient characteristics.

In its post-hearing brief, the Intermediary further explained that the Provider exceeded the national norm in only one of the exception criteria categories, the percentage of pediatric patients. The Intermediary's witness testified that to qualify for an exception, a facility must exceed the national norm in more than one criterion. Moreover, since pediatric patients only represent 11.7 percent of the total patient population, only a small portion of the Provider's total population exceeded the norms. Accordingly, as the majority of the population fell below the norms, the Provider did not meet the 42 C.F.R. §413.184(a) exception criterion that a substantial portion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS trivializes the impact of the Provider's higher than average proportion of adolescents on overall nursing labor, as pediatric patients consume a disproportionate amount of clinical resources when compared to adults.[5] The exception request also satisfied the P.R.M. §2725.1B, criteria as it documented higher nursing time per treatment, a higher staff to patient ratio, and provided a calculation of the cost associated with the more complex medical needs of its patients.[6]

Additionally, CMS' standards are arbitrary and unduly subjective. The CMS witness could not state the standard that a provider must meet to qualify as atypical.[7] CMS' denial also contradicts the Congressional and regulatory intent of providing additional payment for pediatric patients.[8] Also, CMS has no legal basis for requiring time studies for exception requests.[9]

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[5] Transcript (Tr.) at 35-36, 127. Provider Exhibit 13, Attachments 20 and 24.
[6] Provider Exhibit 4, Tables 19 and 20.
[7] Tr. at 199-207, 217.
[8] 69 Fed. Reg. 47530.
[9] The Provider notes that it submitted staffing documentation for cost application purposes at Provider Exhibit 13, Attachments 10 and 19.

CMS' norm for average length of stay is based on outdated data from 1994 which was taken from a predominantly adult population.[10] Likewise, because of its high proportion of pediatric patients, CMS incorrectly concluded that the Provider's lower percent of diabetic and hypertensive patients and lower incidence of mortality indicate typicality.[11]

Moreover, the Provider explained that any apparent conflicting data was primarily due to CMS' failure to correctly comprehend patient data summaries. For example, while 42.9 percent of home patients are pediatric, CMS erroneously concluded that 42.9 percent of pediatric patients dialyze at home.[12]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, program instructions, and the parties' contentions, the Board concludes that CMS properly denied the Provider's exception to the ESRD composite payment rate because the Provider failed to meet its burden of proving that it rendered atypical ESRD services. Additionally, the Provider failed to furnish sufficient evidence to support that its excess costs were directly attributable to the rendering of atypically intense services.

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, "atypical service intensity (patient mix)"), and that its per-treatment costs are reasonable and allowable under cost reimbursement principles. 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.

In order to qualify for an exception based on atypical service intensity, 42 C.F.R. §413.184(a)(1) dictates that:

> 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 . . . (emphasis added)

The Board notes that in reviewing the Provider's exception request, CMS analyzed the Provider's patients' characteristics, as opposed to reviewing the treatments themselves. CMS calculates national norms based on patient characteristics that fall within certain categories that CMS has identified as indicators of atypicality. In its denial,[13] CMS noted

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[10] Provider Exhibit 5.
[11] Provider Exhibit 5, Transcript (Tr.) at 98-99.
[12] Provider Exhibit 2, p.4; Provider Exhibit 13, Attachment 20.
[13] Provider Exhibit 2. CMS stated that "the provider claims that the additional nursing staff services were necessary to provide care to its patient population which has the following characteristics: a) Fifty two or 17.4% of the Provider's patients are under 24

that, other than the higher percentage of patients under the age of 24, it did not believe that the other patient characteristics indicated that the Provider was treating an atypical patient mix.[14] CMS requires that providers seeking exceptions exceed more than one atypicality criterion.[15]

Additionally, 42 C.F.R. §413.180(f) addresses the documentation providers generally must submit with an exception request, while §413.184(b) outlines the additional documentation needed to qualify under the specific atypical service intensity criteria. Relevant to this case, 42 C.F.R.§413.184(b)(2)(i) dictates that a facility must "[s]ubmit documentation on costs of nursing personnel . . . incurred during the most recently completed fiscal year cost report" which includes specific data. Likewise, P.R.M. §§2720 through 2725 provide guidance regarding the exception request process.

The Board concludes that since the Provider failed to submit the requisite nursing personnel cost documentation pursuant to 42 C.F.R. §413.184(b)(2)(i), it could not qualify for an exception. Although the CMS witness suggested that failure to submit such information may not necessarily disqualify the Provider from obtaining an exception,[16] the Board finds that such omission is fatal to the exception request, as neither the Board nor CMS may waive the regulatory requirement.

The Board notes, however, that even if the Provider had submitted the information required under 42 C.F.R. §413.184(b)(2)(i), the Provider was not entitled to an exception

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years of age. This is significantly higher than the national rate of 3.1% for patients under age 24. Thirty seven of the fifty-two patients (including 2 that were transplanted) or 12.4% of total patients were under the age of 18. Therefore, as of 7/1/00, only 35 patients (or 11.7%) remained under the age of 18. b) Of the provider's 299 dialysis patients for fiscal year 2000, over 11.4% are bound to a wheelchair and 8.7% require canes/walkers. c) The average length of an inpatient stay for the provider's dialysis patients was 5.15 days, which is lower than the national rate of 8.3 days. d) Ninety patients or 31.1% have a primary diagnosis of Diabetes, which is below our national average of 33%. e) Thirty-six patients or 12% have a primary diagnosis of Hypertension, which is below our national average of 25%. f) Ten patients or 3.3% received transplants in fiscal year 2000. This is slightly higher than our national transplant rate of 2.9%. g) Thirty-five patients or 11.7% died in fiscal year 2000, which is lower than the national mortality rate of 16%."

[14] The Board notes that CMS recognizes that pediatric patients generally consume a disproportionate amount of services as compared to other patients. However, even using the evidence most favorable to the Provider, the Provider failed to demonstrate that a substantial proportion of treatments were pediatric. Additionally, although the Provider testified that pediatric patients typically treat more than the conventional three times per week (see Tr. at 126-127, 194-195, 213) the controlling regulations do not permit the Board to consider evidence which was not presented within the exception request.

[15] Tr. at 206-207.

[16] Tr. at 219.

as the Provider's data regarding its number of patients, a fundamental component of the atypicality analysis, was conflicting.[17] Accordingly, CMS would also be justified in denying the exception request on that basis alone.

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.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

Date: December 23, 2005

Suzanne Cochran
Chairperson

[17] Provider Exhibit 13 at Narrative, p.1 (229 patients) and p. 13 (254 patients), Attachment 20 (299 patients); Attachment 24 (321 patients).