PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D43

PROVIDER -
Greenwood County Hospital
Eureka, Kansas

Provider No.: 17-0032

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
BlueCross BlueShield of Kansas

DATE OF HEARING -
December 21, 2005

Cost Reporting Period Ended -
October 4, 2001

CASE NO.: 04-0025

INDEX

ISSUE

Whether the Provider was improperly denied a Medicare low-volume adjustment.

MEDICARE STATUTORY AND REGULATORY BACKGROUND

This is a dispute over the proper amount of Medicare payment due a provider of medical services.

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 (DHHS) 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. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b)

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board or PRRB) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Greenwood County Hospital (Provider) is a 46 bed sole community hospital (SCH) located in Eureka, Kansas. On March 21, 2003, the Provider requested that its fiscal intermediary (Intermediary), Blue Cross and Blue Shield of Kansas, allow an additional payment because of a significant volume decrease for the fiscal year ended October 4, 2001 pursuant to 42 C.F.R. §412.92(e).[1] On July 8, 2003, the Intermediary denied the request.[2] On August 25, 2003, the Provider requested that the Intermediary reconsider its decision.[3] The Intermediary denied the reconsideration request on September 15, 2003.[4] The appeal was timely filed on October 14, 2003.

The Provider was represented by Charles R. Hay, Esquire, of Goodell, Stratton, Edmonds, and Palmer, L.L.P. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

[1] Provider Exhibit (Ex.) 1.
[2] Provider Ex. 2.
[3] Provider Ex. 3.
[4] Provider Ex. 4.

A number of events impacted utilization at the Provider and led to the request for the adjustment.

Following the back surgery and unexpected extended recovery period suffered by Dr. Terry Morris – the physician responsible for the majority of the facility's inpatient admissions, the Provider experienced a large decrease in the number of its discharges. Dr. Morris, who had practiced in the Eureka, Kansas community for over 20 years, underwent surgery in March 2001. He expected to be away from his practice for approximately two weeks, but due to a series of complications and additional surgeries, he did not return to full-time practice until November or December 2001.[5] Between September 2000 and September 2001, the number of discharges associated with Dr. Morris' admission fell from 452 to 179.[6]

A few years prior to Dr. Morris' illness, Wichita Clinic, a large multi-specialty group, purchased the practice of Dr. Morris and his partners. As a result, all of the physicians with offices located in Eureka, Kansas practiced as employees of the Clinic. Eureka is located approximately 60 miles from Wichita and is the county seat of Greenwood County. Eureka has a population slightly under 3,000 and the County's population is less than 8,000.

In August 2000 Dr. Mark Basham, a native of Eureka, returned to the community after completing medical studies and joined the Wichita Clinic. Also, as of October 1, 2000, (the beginning of the FYE September 30, 2001), Dr. Stanley Skaer terminated his practice in the community and was no longer on the medical staff.

PROVIDER'S CONTENTIONS:

The Provider claimed that its decrease in discharges was caused by the unforeseeable and unexpectedly long absence of its major admitting physician, Dr. Terry Morris. During the entire period between Dr. Morris' March 2001 surgery through his ultimate return, Dr. Morris continually believed that he would soon improve and be able to return to full-time practice.

Similarly, the Wichita Clinic anticipated that Dr. Morris would be absent only for a short period and did not believe that locum tenens arrangements were appropriate or necessary at the time of his surgery. Also, since Wichita Clinic had no physicians on staff who could be transferred to Eureka on a short-term basis, replacing Dr. Morris would have required the Clinic to make contractual arrangements with another physician or group that supplies locum tenens physicians. Entering such contractual arrangements was deemed an unacceptable option, considering the cost and the lack of assurance that Dr. Morris' patients would be willing to be seen by an unknown physician.

Accordingly, the Provider was faced with what it anticipated would be a brief absence from practice by its highest admitting physician followed by repeated assurances that Dr. Morris would return to full-time practice shortly. From the Provider's standpoint, recruiting a physician was not only impractical, but impossible. All of the physicians practicing in Eureka were employed by the Wichita Clinic, and the Provider had no authority to require the Wichita Clinic to provide a locum tenens physician nor to require the Wichita Clinic to accept a physician that

[5] Provider Ex. 5 at 2.
[6] See Provider Ex. 1 at Attachment 1.

the Provider might recruit.

The Intermediary would apparently have the Provider itself recruit a physician, placing the Provider in direct competition with other members of the medical staff, while expecting Dr. Morris' return to be imminent. However, there was no assurance that either the Wichita Clinic or Dr. Morris' patient base, which had options to seek medical care elsewhere, would respond favorably to this approach. In fact, Dr. Morris believed that many of his patients actually sought other medical options during his absence, and his practice did not immediately return to the same level upon his return.[7]

The Provider claims that it took steps to reduce the impact of Dr. Morris' absence, such as canceling a management contract and implementing various hiring and staffing practices. However, as a small community hospital, it had minimal ability to significantly change in these circumstances.

Moreover, the Intermediary's suggestion that the Provider should have submitted copies of physician recruitment documents to "support the hospital's effort to recruit a physician" is misplaced, as the Provider reasonably continued to believe that Dr. Morris would return within a short time period. Similarly, the Intermediary's suggestion that the Provider should have publicized Dr. Morris' absence based on his medical condition was inappropriate, since Dr. Morris was not the Provider's employee, and such publication would constitute an invasion of privacy.

In response to the Intermediary's speculation that discharges may have declined for "other reasons," that patients may have gone to other hospitals, and that existing staff could have absorbed more utilization,[8] the Provider notes that even if other staff physicians could have covered Dr. Morris' patients and thereby admitted more patients to the hospital, they certainly did not do so, nor was this within the hospital's control.

The Provider notes that Provider Reimbursement Manual (P.R.M.) § 2810.1A.1 (which states that a hospital qualifies for an additional payment if a decrease in its total number of discharges results from an "unusual situation or occurrence externally imposed on the hospital and beyond its control") is inconsistent with 42 C.F.R. §412.92(e)(2)(ii), which requires that the decrease be due to circumstances beyond its control; nevertheless, the Provider would prevail even under the P.R.M.'s stricter language.

Moreover, regarding the amount in controversy, the Intermediary's calculation,[9] which removed items that the Provider termed as "variable," disregards the fact that such costs were inpatient operating costs and thus, by definition, should be included in the adjustment pursuant to the regulations and policy. The regulation at 42 C.F.R. §412.92(e)(3) and the instruction at P.R.M. §2810.1 state that the adjustment is based upon inpatient operating costs and DRG revenue for those costs. In addition, the Intermediary improperly failed to analyze the needs and

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[7] See Provider Ex. 5. For FYE September 30, 2002, Dr. Morris discharges returned to previous levels.

[8] Provider Exhibit P-2.

[9] Provider Ex. 11.

circumstances of the Provider, including the reasonable costs of maintaining necessary core staff and services and the length of time that the Provider experienced a decrease in utilization, as required by 42 C.F.R. §412.92(e)(3)(i)(A) and (C). The Provider contends that neither the regulations or the P.R.M. suggests that the Intermediary may simply eliminate items labeled as "variable" from the low volume payment adjustment. In support of its contention, the Provider, in its post-hearing brief, submitted an additional exhibit (Provider Ex.12) involving another Kansas provider in which CMS concluded that the intermediary should include "variable costs" in its payment adjustment.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is not entitled to an adjustment asserting that the temporary illness of an admitting physician is not a qualifying circumstance under 42 C.F.R. §412.92(e) or P.R.M. §2810.1 because it is not an unusual event beyond the hospital's control. The types of occurrences described in the manual provision must be catastrophic or extraordinary in nature; here, no catastrophe occurred. The Provider was aware of Dr. Morris' plans for surgery and had an opportunity to prepare for his absence. Additionally, the Provider continued to have adequate admitting physician coverage during the period of Dr. Morris' absence.

The Intermediary asserts that because there was no real change in the number of admitting physicians from 2000 to 2001, the decline in discharges could not be tied to Dr. Morris. The discharge patterns of the remaining physicians indicated they could handle an increased patient load. No effort was made to recruit another physician; moreover, doing so was considered unnecessary. Likewise, the Provider failed to assure Dr. Morris' patients that there was adequate coverage for them or that other doctors were available for consultation**.**

The Intermediary also disagrees with the Provider's calculation of the amount of the adjustment, which includes all operating costs. The regulation at 42 C.F.R. §412.96(e) and P.R.M. §2810.1 dictate that the adjustment is limited to fixed and semi-fixed costs. A provider that is entitled to the exception would be entitled to reimbursement up to its fixed costs, as long as it does not exceed the Diagnosis Related Group (DRG) amount.[10] When the variable costs identified by the Provider as $1,003,599 are removed, the total program costs become $1,920,154 and the total DRG payment amount is $1,570,475, leaving $349,679 as the amount in dispute.[11]

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

After consideration and analysis of the controlling law, regulations, manual instructions, the facts of the case, the parties' contentions, evidence presented and post-hearing briefs, the Board finds and concludes that the Provider qualifies for additional reimbursement due to its decrease in discharges.

42 U.S.C. §1395ww(d)(5)(D)(ii) states:

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[10] Tr. at 114.

[11] See Provider Ex. 11.

> In the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control,[12] the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services. (emphasis added.)

The P.R.M. at §2810.1A(1) describes the requirement that circumstances must be beyond the Hospital's control:

> In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects. [13] (emphasis added.)

To determine the adjustment amount, 42 C.F.R. §412.92(e)(3) states:

> The Intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs . . . (emphasis added.)
>
> (i)In determining the adjustment amount, the Intermediary considers-
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies

[12] Likewise, the implementing regulation at 42 C.F.R. §412.92(e)(2)(ii) dictates that for an SCH to qualify for a payment adjustment on the basis of a decrease in discharges, the SCH must "show that the decrease is due to circumstances beyond the hospital's control."

[13] The Board notes that P.R.M.§2810.1A.2 contains examples for the purpose of demonstrating how to calculate the decrease in discharges. The factual circumstances within the examples include the retirement of a community physician and a nursing staff strike.

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization. (emphasis added.)

The P.R.M. at §2810.1B further explains

B. Amount of Payment Adjustment - Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.

Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization, such as food and laundry costs.

In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purposes of this adjustment, many semi fixed costs, such as personnel-related costs, may be considered as fixed on a case-by-case basis.

In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.

The adjustment amount includes the reasonable cost of maintaining necessary core staff and services. The 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.

The Board finds that the decrease in discharges was caused by the unexpectedly long absence of its major admitting physician, Dr. Terry Morris. Most compelling, the Board concludes that throughout the entire period between Dr. Morris' March 2001 surgery and his ultimate return, the Provider, without the benefit of hindsight, continued to reasonably believe that Dr. Morris' health was improving rapidly and he would imminently return to full-time practice.[14] Since it was not reasonably foreseeable that Dr. Morris' return would take as long as it did, the Provider conducted itself prudently given the totality of the circumstances.

The Board also notes that recruiting a physician was practically impossible,[15] as it would have placed the Provider in direct competition with other medical staff members, while expecting Dr. Morris' return to be imminent. Also, there was no assurance that Dr. Morris' patients who had options to seek medical care elsewhere, would respond favorably to this approach.

Moreover, the Intermediary's suggestion that the Provider should have publicly advertised for a replacement physician is misplaced, as the Provider reasonably continued to believe that Dr. Morris would return within a short time period. Likewise, the Board believes that if the Provider were to have contacted Dr. Morris' patients directly such action would have constituted an invasion of privacy. The Board also finds that the Provider mitigated its losses to the best of its ability, by canceling a management contract and implementing various hiring and staffing practices.[16] Contrary to the Intermediary's contention, the Board finds that the Provider had no control over whether Dr. Morris' patients chose to use another of the hospital's admitting physicians; therefore, it had no ability to control the impact that Dr. Morris' absence had on its inpatient utilization.[17]

The Board, however, finds that the Intermediary correctly chose not to consider within its calculation those costs which the Provider, by its own election, labeled as variable.[18] The Board finds that 42 C.F.R. §412.96(e) and P.R.M. §2810.1 explicitly dictate that the adjustment is limited to fixed and semi-fixed costs.[19] While the Provider contends that the reference to

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[14] See Intermediary Ex.6 at 2,5.

[15] Provider Ex. 6 at 3.

[16] See Provider Ex. 6 at 5.

[17] The Board also notes that between FYEs 9/30/00 and 9/30/01, Dr. Morris'net decrease in discharges (273) was greater than the total of the combined doctors' decrease in discharges (224). See Intermediary Ex. 8. Moreover, the net discharges for the four doctors besides Dr. Morris (Drs. Bradshaw, McClintick, Skaer, and Basham) increased by 49. Also, the Board agrees with the Provider that Drs. Bradshaw's, Mc Clintick's and Skaer's decrease of 97 total discharges may be attributable to Dr. Basham's addition to the staff. Since Dr. Basham was native to the local community, it is likely he may have absorbed some of these doctors' patients (Tr. at 49). Likewise, as Dr. Morris' discharge rate had decreased from the previous years, the Board speculates that such reduction may have been attributable to his health prior to the surgery.

[18] Provider Ex.1, attachment 3; Provider Ex. 11.

[19] The Board notes that while consistent with the regulation, the text at P.R.M §2810.B (Intermediary Ex. 7 at 2) explicitly dictates that fixed (and semi-fixed) costs may comprise the

"operating costs" within the regulation allows some variable costs to be included in the adjustment, such reference applies to the methodology for calculating the limit of an adjustment. Accordingly, the $1,003,599 of variable costs identified by the Provider should be excluded from the low volume adjustment. Since the total program cost is now reduced to $1,920,154 and the DRG payment amount was $1,570,475, the Provider is entitled to an adjustment of $349,679.[20]

DECISION AND ORDER:

The Intermediary's denial of the Provider request for a low volume adjustment is reversed.

The Provider is entitled to a low volume adjustment of $349.679.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: August 29, 2006

Suzanne Cochran, Esquire
Chairperson

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adjustment, the use of the term "operating costs" in the subsequent examples (Id at 8-12) may suggest that variable costs could be included. However, the Board finds that the examples are intended to demonstrate how to calculate the adjustment limit as opposed to determining which costs should be included in the adjustment.

[20] See Intermediary Ex. 11.