PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D52

PROVIDER -
Mark Reed Hospital
McCleary, Washington

Provider No.: 50-1304

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Service

DATE OF HEARING -
May 12, 2005

Cost Reporting Period Ended -
December 31, 2001

CASE NO.: 04-0565

INDEX

ISSUES:

1) Whether the Intermediary's adjustment to direct nursing costs was proper.

2) Whether the Intermediary's adjustment increasing the total patient days to include respite care days was proper.

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

Mark Reed Hospital (Provider) is located in McCleary, Washington and has been deemed a Critical Access Hospital (CAH)[1] under the Medicare program. Medicare reimbursement of CAHs is based upon their reasonable costs.[2] The Provider's NPR for fiscal year ended December 31, 2001 was issued on July 24, 2003. The Provider filed a timely appeal of the NPR and has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R. §§405.1835-1841.

Michael R. Bell, C.P.A. of Michael R. Bell & Company represented the Provider. Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association represented the Intermediary.

[1] See 42 U.S.C.§§1395i-4, 1395x(mm); 42 C.F.R. §485.610.
[2] 42 C.F.R.§413.70.

BACKGROUND - Issue 1 (Nursing Costs)

During the desk review of the appealed cost report, the Intermediary discovered a 731% increase in the costs reported on Worksheet A for the Adults and Pediatrics (A&P) cost center and determined to review this issue during the field audit. As a result of the audit work, the Intermediary noted that on March 28, 2001, the Provider's Assistant Administrator issued an interoffice memorandum[3] to its nursing staff regarding nursing time allocation. The memorandum stated:

> There is a change in how you need to allocate your time on your time cards.
>
> Previously, you had been directed to allocate the majority of your time to the ER. This is no longer the case, and this change is very important to our reimbursement.
>
> You are to allocate to ER only time that you are actually taking care of an ER patient (same for AHC, Dietary, etc.) All time that is not specifically allocated to another department now goes to acute care, which is considered by Medicare to be your "home" department. [4]
>
> Your immediate attention to this change is greatly appreciated.[5]

The Intermediary determined that the Provider's assignment of all of the nursing staff's "available" time to acute care (the Adults and Pediatrics (A&P) cost center) was inappropriate, and that available time should be allocated to the other departments as well. Lacking the actual time spent in the A&P cost center for the last three quarters of the year, the Intermediary made an adjustment allowing twenty-four nursing care hours for every patient day as the direct patient care time for the A&P cost center. Using that, and the time actually spent in other departments based upon time records, the Intermediary allocated the standby time based on the direct time to all of the areas where the nursing staff worked. This resulted in an adjustment which shifted costs from the A&P cost center into the emergency room (ER) cost center.[6]

PROVIDER'S CONTENTIONS - Issue 1 Nursing Costs

The Provider contends that two nurses were required to be in the facility at all times to ensure patient and staff safety, promote good patient care, and to allow the Provider to recruit and retain an adequate number of nurses. Moreover, the assignment of the nursing stand-by costs to the acute care home department is consistent with its peers' practice, and its as-filed acute care and ER costs

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[3] Intermediary Exhibit (Ex.) 1 at p.7.

[4] The premise of a "home department" was that the nurses' job required them to be in one department unless specific patient needs dictated otherwise. The impact of a "home department" was that all of the time not specifically spent on patients or administrative tasks would default into the "home department." Tr. 17 & 18

[5] This record keeping change, while formally announced in a March 28, 2001 memorandum, was actually implemented for all of March. Tr. 17

[6] See Intermediary Position Paper at 3-4; Intermediary Ex. 2.

were within its peer group's range of costs. Additionally CAHs, by their very nature, are expected to have high per diem costs and low utilization, therefore, the Intermediary's claim that the Provider's high per diem cost supports its adjustment is unwarranted.

The Provider also claims that its cost reporting methodology is consistent with the controlling federal and the state staffing requirements. The Provider claims that, according to federal CAH regulations, hospitals must provide emergency room services and have a physician or mid-level practitioner available to be on-site within 30 minutes.[7] Likewise, as a trauma program, the state does not require that registered nurses be in the facility at all times.[8] However, the state requires that nurses be on location to comply with inpatient acute care requirements;[9] accordingly, nurses' stand-by costs should consistently be recorded within the acute care department.

INTERMEDIARY'S CONTENTIONS - Issue 1 (Nursing Costs)

The Intermediary contends that the Provider's time keeping method i.e., utilizing a "home department," did not accurately allocate nursing costs to where nursing services were performed. To support its adjustment, the Intermediary noted that the Provider's inpatient capacity was severely underutilized, and that the most frequently used outpatient service was the ER. Additionally, the "home department" methodology is unsupported by regulation, policy, or accounting theory. While there were no material changes regarding the patients' use of services or staffing duties when the Provider redesignated its "home department" from ER to A&P, the redesignation shifted nursing costs to the A&P cost center and significantly increased Medicare reimbursement. The Intermediary's adjustment attempts to correctly report the costs to achieve a proper per diem and an equitable apportionment of costs to the Medicare program.

Also, the state laws which the Provider cites to support its position do not suggest how time should be reported. Likewise, while the Provider contends[10] that its timekeeping practices were consistent with peer hospitals, the Intermediary claims that no such conclusion can be drawn.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION - Issue 1 (Nursing Costs)

To qualify as a CAH under Medicare, an applicant must be a small rural hospital that provides both inpatient and emergency room services. The federal requirements do not require a CAH to keep a nurse on-site if there are no inpatients.[11]

The State of Washington requires nurses to be on the premises for providers that furnish emergency and/or inpatient services. Regarding providers that provide emergency services, the State requires,

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[7] Provider's Post-Hearing Brief – Nursing Service Cost at 4 and Proposed Findings of Facts and Conclusions of Law.

[8] Provider's Post-Hearing Brief – Nursing Service Cost at 7 and Proposed Findings of Facts and Conclusions of Law

[9] Id.

[10] The Provider cites Provider Ex. 9 and Intermediary Ex. 10 as support.

[11] See 42 U.S.C.§1395i-4(c).

at WAC 246-320-365 [12]

> …(14) If providing an emergency care unit or service, provide basic, outpatient emergency care including:
>
> …(b) At least one registered nurse skilled and trained in care of emergency department patients on duty in the hospital at all times, and:
>
> (i) Immediately available to provide care; and
> (ii)Trained and current in advanced cardiac life support
>
> (emphasis added.)

Likewise, for providers furnishing inpatient care services the State requires, at WAC 246-320-345, that hospitals

> …(2) Have a registered nurse in the hospital at all times and available for consultation
>
> (emphasis added.)

Providers must comply with both federal and state regulations; accordingly, this Provider was required to have a registered nurse in the hospital at all times pursuant to WAC 246-320-365(14)(b) and WAC 246-320-345(2). Additionally, the Board finds that because these state requirements are practically identical, neither one should be elevated above the other. Accordingly, the Board finds that the stand-by time in dispute should be equally allocated between the Adults and Pediatric (acute) and ER cost centers. Moreover, the stand-by time should be exclusively divided between these cost centers, as they are the only areas which incur the stand-by costs.

To implement our finding regarding the stand-by time allocation, the Board recognizes that no contemporaneous records exist which accurately differentiate and quantify either the nurses' actual ER time for January and February 2001, or the nurses' actual A&P time for March through December 2001. Such records are non-existent because the nurses assigned both their actual and stand-by time to the respective assigned "home department," as instructed. Moreover, while the record indicates that time records existed and tabulations were computed for January, February, March and July 2001,[13] it is not clear whether time records and tabulations exist for the other months within the cost year.

Accordingly, the Intermediary is instructed to determine the actual ER time for January and February 2001 by annualizing the March and July (and any other time periods in which auditable time studies exist) actual ER time and to apply a corresponding prorated monthly figure to those months for which time records do not exist. Likewise, to determine the actual A&P time for March through December, the Intermediary should use the January and February data to determine the

average monthly A&P time and apply it to March through December. For the other cost centers, the

[12] Intermediary Ex. 3 at p. 1.
[13] See Intermediary Exs. 8 and 12.

Intermediary is instructed to annualize the data from January, February, March, and July (and any other time periods for which existing time studies exist) and to apply a corresponding prorated monthly figure to those months for which time records do not exist.

Once these actual times are quantified, the remaining claimed time, which represents stand-by time, should be allocated equally and exclusively between A&P and ER.

BACKGROUND – Issue 2 (Respite Care)

During the fiscal year under appeal, the Provider furnished ten days of care to a respite care patient. The Provider did not include the days and carved out the costs at $127 a day;[14] the amount the Provider alleged was equal to the cost of providing respite care. The Intermediary adjusted total days to include the ten days and allocated the costs in the same manner as general inpatient care costs.

PROVIDER'S CONTENTIONS - Issue 2 (Respite Care)

To support its methodology, the Provider noted that the cost of respite care is less than inpatient acute care (consistent with Program Memorandum A-01-81).[15] Likewise, the Provider added no additional staff to accommodate the respite care patients, and the nursing staff distinguished respite care patients from acute care patients. Accordingly, the cost of $127 per day, which is the Provider's charge for the care, should be carved out. As an alternative methodology, the Provider suggested that the actual cost of respite care be identified as non-allowable.[16]

INTERMEDIARY'S CONTENTIONS - Issue 2 (Respite Care)

The Intermediary noted that its adjustment was reasonable for lack of a better alternative. The Intermediary argued that the respite care patients received the same types of services as the other acute care patients,[17] and the Provider's proposed remedies conflict with Medicare's prohibition against cost shifting.[18] In addition, the Provider's argument that respite patients should be considered as swing bed or hospice patients is not supported by regulation or policy.

FINDING OF FACT, CONCLUSIONS OF LAW AND DISCUSSION – Issue 2 (Respite Care)

The Intermediary's adjustment is affirmed. There is no legal authority which would permit the Intermediary to either carve out the respite care costs or to alternatively treat such costs as unallowable as the Provider proffers.

[14] Transcript (Tr.) at 32
[15] Provider Ex. 14
[16] Tr. at 371. Provider's Post-Hearing Brief (Respite Care)
[17] Tr. at 25-26.
[18] See 42 U.S.C. 1395x(v)(1)(A)

DECISION AND ORDER:

The Intermediary's adjustment to nursing costs is modified. The stand-by time in dispute should be equally and exclusively allocated between the Adults and Pediatric (acute) and ER cost centers in accordance with the Board's methodology described herein.

The Intermediary's adjustment increasing the total patient days to include respite care days is affirmed.[19]

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: September 14, 2006

Suzanne Cochran, Esquire,
Chairperson

[19] The Board notes that by letter dated June 30, 2005, the Provider requested that the Board not consider the Intermediary's Post-Hearing Brief. The Provider contends that because the Intermediary's brief was dated and filed several days after the post-hearing date deadline, the Intermediary gained an unfair advantage by having access to the Provider's timely filed post hearing brief. The Board hereby denies the Provider's request, as there is no evidence that the Intermediary added a new argument or evidence directly addressing the Provider's brief. Moreover, given the time frame of the parties' post-hearing submission, the Board finds it unlikely that the Intermediary would have had time to take advantage of having access to the Provider's brief.