PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D12

PROVIDER -
El Camino Hospital
Mountain View, California

Provider No.: 05-0308

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC-CA

DATE OF HEARING -
November 17, 2005

Cost Reporting Period Ended -
June 24, 2000

CASE NO.: 03-1464

INDEX

ISSUE:

Whether all of the Provider's outpatient total cost, total charges, and Medicare charges for separately billable End Stage Renal Disease (ESRD) drugs should be reported together on line 56 (drugs charged to patients), on line 57 (renal dialysis), or on a separate cost center line of the Medicare cost report.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare program generally reimburses providers for outpatient end stage renal dialysis (ESRD) services through a "composite" rate set prospectively by CMS that is intended to reimburse the providers for all typical costs associated with a dialysis treatment. 42 C.F.R. §413.174. However, at issue in this case are two ESRD drugs that are separately billable and reimbursable on a reasonable cost basis outside of the outpatient ESRD composite rate.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

El Camino Hospital (Provider) is a 341-bed hospital located in Mountain View, California that provides short-term acute care, psychiatric, skilled nursing, and outpatient services. The Provider also operates a Medicare certified outpatient renal dialysis facility serving ESRD patients. During its fiscal year ended June 24, 2000 (FY 00), outpatient ESRD services were provided on the main campus of the Provider and at two outpatient dialysis centers; namely, Evergreen Dialysis Unit and Rose Garden Dialysis.[1] The Provider furnished outpatient renal dialysis services and was reimbursed for most of its

[1] Transcript (Tr.) at pp. 34 and 35.

outpatient ESRD services through Medicare's composite rate reimbursement system. However, there are certain separately billable ESRD injectable drugs that are not reimbursed under the composite rate. Under Medicare regulations set forth at 42 C.F.R. §413.174, hospital-based ESRD facilities such as the Provider are reimbursed for separately billable ESRD drugs on a reasonable cost basis. No separate payment is made for the staff time expended to administer the drugs, as these services are reimbursed through the composite rate.[2] Specifically, the separately billable renal dialysis costs/charges at issue in this case relate to the following two injectable drugs: calcitriol (Calcijex) and iron dextran (Infed).[3]

During fiscal year ending June 24, 2000, the Hospital provided these medically necessary injectible drugs to its ESRD patients.[4] It billed the Medicare Program for these drugs and received interim payments from the Intermediary during the year. In its filed Medicare cost report, the Provider reported the total cost, total charges, and Medicare charges associated with its separately billable ESRD drugs in the Renal Dialysis cost center Worksheet A, (line 57 of in the cost report).[5] At audit, the Intermediary reclassified the Medicare outpatient revenue for these separately billable ESRD drugs to the "Drugs Charged to Patients" cost center (line 56).[6] There was no audit adjustment made to reclassify the total cost or total charges for the separately billable drugs out of the Renal Dialysis cost center.[7]

With respect to the separately billable ESRD drugs at issue, the Provider and Intermediary agree that the following dollar amounts were included on the listed lines on the latest audited Medicare cost report:

Separately Billable ESRD Drug Total Cost in Line 57	$419,460
Separately Billable ESRD Drug Total Charges in Line 57	$2,696,088
Separately Billable ESRD Drug Medicare Charges in Line 56	$1,375,944

Exhibit PS-9 (stipulated fact number 5).

There is approximately $100,000 in Medicare reimbursement at issue in this appeal. The Provider timely appealed the adjustment at issue to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Jon P. Neustadter, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

---

[2] See, HCFA Pub. 15-1, §2711.2.B.1.
[3] See, Provider Exhibit PS-9 (stipulation fact number 1).
[4] See, Provider supplemental position paper, page 2.
[5] See, Provider Exhibit PS-9 (stipulated Fact number 3).
[6] See, Provider Exhibit PS-9 (stipulated fact number 4).
[7] Tr. at p. 29; Provider's Post-Hearing Brief, pages 3-4.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, evidence, parties' contentions and post-hearing briefs, finds and concludes that the proper treatment of the ESRD injectable drugs (Calcijex and Infed) is to report the total and Medicare costs and charges in the Drugs Charged to Patients cost center (line 56 of the Medicare cost report). The Board observes that the Intermediary did re-classify the Medicare outpatient charges for these drugs to that cost center. However, there was no audit adjustment reclassifying the total charges and costs of these drugs to the Drugs Charged to Patients cost center. The Board finds that this treatment results in a mismatching of charges and costs that needs to be corrected.

The Provider contends that the charges and costs of these drugs should remain in the renal dialysis cost center (line 57 of the Medicare cost report) or in the alternative, that these separately billable ESRD drugs costs belong in their own separate cost center. These drug costs would then be apportioned to Medicare based on the ratio of Medicare charges to total charges for these drugs only. The Intermediary acknowledges that its original adjustments were inadequate, and proposed to correct its determination by reclassifying the total costs and total charges for these drugs to all other drugs charged to patients in the Drugs Charged to Patients cost center on line 56.

The Board finds that there are specific instructions in the Provider Reimbursement Manual (PRM), Part 2 for accumulating and reporting renal dialysis costs and their subsequent apportionment to Medicare. The Board, although not bound by the provisions of the PRM, does give it great weight, and finds that PRM, Part 2, §3610 (Worksheet A – Reclassification and Adjustment of Trial Balance of Expenses) – provides detailed instructions for reporting costs in specific cost center line items of the Medicare cost report. Renal dialysis costs are specifically addressed on line 57 as follows:

> Line 57 – If you furnish renal dialysis treatments, account for such costs by establishing a separate ancillary service cost center. In accumulating costs applicable to this cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services rendered after July 31, 1983, are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drug Epoeitin include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.[8]

The Board finds that this manual provision clearly states that no other ancillary services should be included in this cost center. The Board concurs with the parties in that the

[8] See, Intermediary Exhibit I-6.

drugs in question are separately billable and considered ancillary services. Since Calcijex and Infed are drugs chargeable to patients, they cannot, by definition, be included on line 57 of the cost report. The Provider argues that the use of these drugs is an integral and direct part of the renal dialysis department's services and that they do not constitute "other" ancillary services of another cost center. On the contrary, the Board finds that these drugs are not commonly provided to all ESRD patients, but on an as-needed basis. The Board also finds that these ESRD drug are similar to any other separately billable drug that a hospital would furnish to a patient, such as in the operating room or labor/ delivery room cost centers. The Provider further argues that basic principles of cost finding and apportionment require the separately billable ESRD drug charges and costs to be in the renal dialysis cost center. However, the Board finds that the cost report instructions for line 57 refute that argument.

The Provider argues that some of the cost report instructions relied upon by the Intermediary do not properly take into account the Provider's method of separately handling ESRD drugs through an outside management company. The Board finds that inclusion of all the costs and charges for all drugs charged to patients in one cost center is an appropriate and reasonable treatment of these items. It is irrelevant whether the drug is acquired by the in-house pharmacy or an independent contractor. The Board finds relevant the fact that the drugs are administered to all patients by the facilities' staff in a comparable manner.

The Provider further argues that co-mingling of the costs and charges of ESRD drugs with all other chargeable patient drug costs and charges results in a dilution of the Medicare program's share of the ESRD drug costs incurred. The reason for the dilution is that the cost of the ESRD drugs is higher than the average cost of non-ESRD drugs relative to the Provider's customary charges for the respective drugs; i.e., the ratio of costs to charges for ESRD drugs (31.4%) is greater than the ratio of costs to charges for the combined average of all other hospital drugs exclusive of ESRD drugs (12.1%). The Provider also contends that the Medicare outpatient utilization of ESRD drugs (51.0%) is significantly greater than the Medicare outpatient utilization of non-ESRD drugs (1.6%), and that these differences in the cost to charge ratios and Medicare utilization ratios support the separate reporting of ESRD drugs in order to accurately determine the cost of services to Medicare beneficiaries..

The Board finds that cost finding is not an exact science that addresses each and every aspect of every type of cost. A cost center such as Drugs Charged to Patients addresses all of the various types of drugs furnished to patients without regard to the cost or charge of any particular drug. The cost center accumulates the costs of these drugs furnished to all patients and then distributes them based on a ratio of Medicare program charges to total charges. The total charges include charges for all types of drugs utilized for all patients. The Board finds that this apportionment of costs to the Medicare program is reasonable. The inclusion of these ESRD drug costs and charges, even in light of their unique utilization, is acceptable in light of this overall cost finding aggregation process.

The Provider argues that if the separately billable ESRD drug costs and charges cannot remain in the renal dialysis cost center, the Provider should be allowed to establish a separate cost center to accumulate the ESRD drug costs and charges. The Intermediary counter argues that establishing such a cost center is inappropriate because ESRD drugs alone do not meet the definition of a cost center. The Intermediary further argues that the Provider mistakenly relies on Worksheet I of the Medicare cost report, which is intended to capture ESRD service costs for the purpose of developing and updating ESRD composite rates. Finally, it argues that the Provider's witness admitted that he had never seen another hospital treat ESRD costs as the Provider had proposed.[9]

The Board finds that it is inappropriate to establish a separate cost center for the drugs in issue, and that the Medicare cost reporting forms and instructions address how drugs charged to patients are to be reported. The Drugs Charged to Patients cost center includes a wide range of costs, charges and utilizations. Thus, establishing a new cost center for ESRD drug costs simply because they have a unique utilization pattern is inappropriate. Two drugs cannot be considered a "cost center" as that is defined in PRM §2302.8. The Provider's suggestion that a separate cost center be established for these drugs is essentially "cherry picking" to maximize Medicare reimbursement. This process is analogous to providers directly assigning certain overhead costs to cost centers that have higher than average Medicare utilization – a "discrete cost finding" process that is available only in limited circumstances. The Board rejects this type of cost finding unless the direct assignment of costs is done for all types of overhead costs. Finally, the Board concurs with the Intermediary's observation that the Provider's witness' statement that he has never seen this done before is relevant and significant. It is obvious that establishing a separate cost center for ESRD drug costs is not a common and accepted practice in the health care industry.

Based on the above, the Board concludes that the appropriate treatment of the ESRD drug costs in question is to accumulate all drug costs in the Drugs Charged to Patients cost center (line 56), and the charges relating to those drugs should be reported in the same cost center for purposes of determining Medicare's share of those costs.

DECISION AND ORDER:

The Provider's total costs, total charges, and Medicare charges associated with the separately billable ESRD drugs at issue should be reported in the Drugs Charged to Patients cost center on line 56 of the Medicare cost report. The Intermediary's adjustments are modified.

[9] Tr. at 91-108.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: December 21, 2006

Suzanne Cochran
Chairperson