PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D16

PROVIDER -
Martin Luther King, Jr./Drew Medical Center
Los Angeles, California

Provider No.: 05-0578

vs.

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

DATE OF HEARING -
June 16, 2005

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 03-0818

INDEX

ISSUE:

Whether the Intermediary properly increased the number of available beds used to determine the Provider's indirect medical education (IME) payment.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement 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) 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:

The Medicare Act at section 1886(d)(5)(B) provides that teaching hospitals that have residents in approved graduate medical education (GME) programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. §412.105 establish how the additional payment is calculated. The ratio of residents to beds multiplied by the Diagnostic Related Group (DRG) payments is used to determine a provider's payment. The higher the ratio of residents to beds, the greater will be the payment, i.e., fewer available bed results in higher reimbursement for a provider. The determination of the number of beds, based on available bed days, is specified at §412.105(b).

> (b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not

> including beds or bassinets in the healthy newborn nursery, custodial care beds, or beds in excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. §412.105(b).

The number of available beds is further discussed in CMS Pub. 15-1 §2405.3G. It states:

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service. In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count.

An additional interpretive guide used by intermediaries is Blue Cross Blue Shield Association Administrative Bulletin 1841, 88.01. (BCBSA AB 1841, 88.01). It states:

> In a situation where rooms or floors are temporarily unoccupied, the beds in these areas must be counted, provided that the area in which the beds are contained is included in the hospital's depreciable plant assets, and the beds can be adequately covered by either employed nurses or nurses from a nurse registry. In this situation, the beds are considered "available" and must be counted even though it may take 24-48 hours to get nurses on duty from the registry.

It further states that "[w]here a room is temporarily used for a purpose other than housing patients (e.g., doctors' sleeping quarters), the beds in the room must be counted, provided they are available for inpatient use on an as needed basis."

The dispute in this case arises over the proper number of available beds to be used by the Intermediary to calculate the Provider's IME adjustment.

SUMMARY OF FACTS:

Martin Luther King, Jr./Drew Medical Center (Provider) is an acute care hospital located in Los Angeles, California. On its fiscal year ended (FYE) June 30, 2000 cost report, the Provider reported 246 beds for purposes of the IME payment. The Intermediary

conducted a physical inspection of the Provider's facility and determined that the Provider had 382 available beds. The Provider and the Intermediary reached a stipulation in which they reduced the number of beds at issue to 49. (See Stipulation). The beds at issue are comprised of: (1) 18 beds in rooms used for storage; (2) 17 beds in on-call rooms (i.e., used by residents to sleep in during their on-call periods); and (3) 14 beds in closed units.

The Provider was represented by Anita D. Lee, Esquire, of the County of Los Angeles. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the appropriate standard in determining the number of available beds is "achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity." See 69 FR 49094 (Aug. 11, 2004). The Provider asserts that the Intermediary erred in focusing exclusively on whether a bed can be made physically available for patient use within 24 to 48 hours.

The Provider contends that the beds in rooms used for on-call residents are not readily available for patient use because of the Provider's contractual obligation to provide on-call rooms to residents. The Provider also contends that beds assigned to rooms used for storage purposes could not be readily available to Provider patient care because of a lack of storage space on and off-site. To return those rooms and beds back into service would require other patient rooms to be taken out of service, resulting in no net.

The Provider contends that the facts in the current case are distinguishable from those in the Administrator's decision in Santa Clara Valley Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, HCFA Administrator's Decision, March 28, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,230 (Santa Clara), wherein it was determined that resident sleeping rooms could be converted to patient use and other arrangements could be made for residents using the rooms. The Provider notes that it was contractually obligated to provide on-call space for its residents and that it had no alternative way to meet that obligation.

The Provider asserts that the census in it closed units (2E, 3E and 5E) should be taken into consideration in determining whether to include the beds from those units in its bed count, as 42 C.F.R. §412.105(b)(1) was modified in 2004 to exclude from the count beds which were in a unit or ward that was not occupied to provide acute patient care at any time during the three (3) preceding months. The Provider maintains that the modified regulation would exclude the beds in those units from its bed count, and that because CMS described the new standard as a "clarification and refinement of our policies," it should be applied retroactively to the year in issue.

Finally, the Provider contends that the units in question could not, in fact, be converted to patient use in 24 to 48 hours, which is the standard used in BCBSA AB 1841, 88.01. The

Provider asserts that the assumption that there was available equipment and staffing is incorrect. The Provider asserts that it lacked adequate monitors for Units 2E and 3E, which were licensed ICU units, and that it had difficulty obtaining ICU nursing staff from other units or the registries to staff these units. Moreover, it did not have adequate ancillary and support staff for the closed unit 2E.

The Intermediary contends that the Provider bears the burden of showing that the areas which it claims are unavailable could not be reopened for patient care within 48 hours as required by BCBSA AB 1841, 88.01. The Intermediary argues that the storage and on-call rooms have not lost their character as patient rooms and can easily be converted back to patient use, because they are located in units that already had active patient care beds. The Intermediary maintains that the Administrator's decision in Santa Clara held that on-call rooms were still available within the meaning of the IME regulation. The Intermediary asserts that the Provider could easily have de-licensed these beds or removed the oxygen lines to them, and either of these two actions would have sufficed to make them unavailable.

The Intermediary also contends that the 2004 amendments to the IME regulation and the preamble discussion mark a departure from the standard applied in the year at issue and should not be used by the Board in deciding this case.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the parties' contentions and evidence submitted, the Board majority finds and concludes that the beds in rooms converted to on-call rooms were unavailable for patient care, but that all other beds at issue were available for patient care. With regard to the Provider's position that the Board must utilize the modified regulation (42 C.F.R. §412.105(b)(1)) concerning the counting of available beds in determination of its IME costs, the Board majority concludes that the 2004 change in the regulation and subsequent changes in the rule are a departure from the standard pertaining to the year at issue and should not be applied.

The Board majority notes that the parties have stipulated that there were 17 beds in various rooms throughout the facility that were converted for use as on-call rooms. See Stipulation at 1(b) and (e). The Provider contends that it had a contractual obligation to provide on-call rooms to residents and no place to provide them except in converted patient rooms. The Intermediary contends that the beds must be considered available because the Provider could convert the room back to patient use in a short period of time. The Board majority finds that the Provider presented clear evidence of its long-term contractual obligation to provide on-call rooms for its residents. Exhibit P-18, Article 11 at page 26. The requirements for on-call rooms include functional locks, 7 day a week availability, and lockers for the secure storage of residents' personal effects. Id. The evidence in the record indicates that the Provider converted these rooms to on-call rooms, as they no longer contained patient furniture or monitors and, instead, were furnished with bunk beds, computers and lockers. In addition, residents were given keys to these locked rooms. The evidence in the record indicates that the Provider's need for on-call

space exceeded its available designated space necessitating the conversion of patient rooms into on-call rooms. Tr. at 46-47. The Provider also indicated that it had used patient rooms as on-call space for many years, Exhibit P-14 and Tr. at 107; and they were used daily for that purpose. Tr. at 38 and 78. The Board majority finds that there is sufficient evidence to show that the Provider had permanently converted these rooms and associated beds to on-call use, just as the Provider had converted other rooms to uses such as office space, examination rooms, lounges and libraries. There is no dispute that the rooms were used as on-call rooms and that there was no expectation of changing the rooms back to patient care. Since these beds were no longer permanently maintained for patient use, the Board majority finds that they should be excluded from the bed count for the purpose of computing the Provider's additional IME reimbursement.

The parties stipulated that there were 18 beds in various rooms throughout the facility that were used for storage. See Stipulation at 1(a) and (e). The Provider contends that it had no alternative than to use vacant patient rooms to store temporarily unneeded patient equipment and furniture. The Intermediary contends that the beds in the patient rooms used for storage must be considered available because the Provider could convert the rooms back to patient use in a short period of time. The Provider indicated that it used both patient rooms and office space for storage, and that the items that they stored included patient care beds, IV poles, patient monitors and other patient room furniture. Tr. at 35. The Provider also indicated that if it needed to use a patient room which was being used for storage, it would have to relocate the equipment to another vacant area, most likely another vacant patient room, and then ensure the room was safe for patient care. Tr. at 37. The Provider indicated that the storage areas in patient care rooms could be returned to patient care in a minimum of 24-48 hours. Tr. at 81. The Board majority did not find sufficient evidence that the Provider modified the storage rooms in any significant way to indicate that they were permanently unavailable for patient care. The beds in the storage rooms should be considered available and included in the count of available beds for IME purposes.

The parties stipulated that Unit 2E had five beds during FYE 6/30/00. See Stipulation at 1(c). The Provider states that the neurological intensive care unit (NICU) located in Unit 2E was moved in May 1999, and that Unit 2E was not used for patient care during FYE 6/30/00. The Provider contends that the beds in the unit were unavailable because beds and equipment were removed and monitors and staffing were not readily available. The Intermediary contends that the beds in Unit 2E must be considered available because the Provider could convert the room back to patient use in a short period of time. The record contains a form filed by the Provider with the State of California that provides a record of client accommodations approved for licensed care which identifies the approved use of individual rooms and approved capacities. See Exhibit I-6. The report was filed on April 18, 2001. The Intermediary used this report as a starting point for its walk-through survey conducted on July 21, 2001. In the form, Unit 2E is reported as having 5 beds when it was filed on April 18, 2001, even though it is reported as empty on the date of the walk-through. The Board finds that the five beds were not removed from 2E until sometime after April 18, 2001 and were present in the unit throughout FYE 6/30/00. Even though these beds may not have been used or staffed, the Board finds that they were

present during the relevant period and therefore available for patient care. The beds in Unit 2E should be considered available and included in the bed count for IME purposes.

With regard to the beds in Unit 3E, the parties stipulated that Unit 3E had 12 beds during FYE 6/30/00 and that six were used and six were unused. See Stipulation at 1(d). The Provider states that the six beds on the north side of Unit 3E were licensed as a surgical ICU, and there was no utilization of these beds because they were relocated to its trauma center. Tr. at 58. The Provider contends that the beds in the unit were unavailable because beds and equipment were removed and monitors and staffing were not readily available. The Intermediary contends that the beds in Unit 3E must be considered available because the Provider could convert the room back to patient use in a short period of time. The Board notes that in the listing of client accommodations, Unit 3E is reported as having 12 beds when it was filed on April 18, 2001 and at the time of the walk-through in July 2001 Unit 3E had 6 used and 6 unused beds. Even though all these beds may not have been used or staffed, the Board finds that the 12 beds were present in Unit 3E throughout FYE 6/30/00 and, therefore, were available for patient care and should be included in the count of available beds for IME purposes.

The parties stipulated that the three beds in Unit 5F were designated for patient care. See Stipulation at 1(e). However, the Provider contends that the three beds were only used rarely for pediatric isolation and overflow and should not be considered available for patient care. The Intermediary counters that the Unit 5F beds were used for patient care and therefore must be considered available. The Board agrees with the Intermediary that even though the beds were seldom used, they were still available for patient care and must be counted as available for IME purposes.

DECISION AND ORDER:

The Board majority finds that the beds in rooms converted to on-call rooms were unavailable for patient care. The Board majority finds that the beds used for storage were available for patient care. The Board finds all other beds at issue were available for patient care. The Intermediary's adjustments to available beds are modified accordingly.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S. (Dissenting regarding on-call beds)
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes (Dissenting regarding beds in storage areas)

DATE: January 26, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

Dissenting opinion of Gary Blodgett

I respectfully dissent with the Board majority's opinion regarding the availability of Provider's "on-call" beds.

The Parties have stipulated that the availability of forty-nine beds involving the following three categories are at issue in this case:

1. Eighteen beds in rooms used for storage
2. Fourteen beds in closed units of the hospital
3. Seventeen beds in rooms used by residents and interns while they were "on-call"

The Board majority found the beds used for storage and those in closed units of the hospital to be available beds but the on-call beds to not be available.

I respectfully dissent with the Board majority's decision to exclude the 17 on-call beds from the available bed count used to determine Provider's IME payment.

Physical availability is the principle that governs whether or not hospital beds can be made available for patients, and the Board in previous similar cases has consistently held that if rooms and nursing personnel can be made available within 24-48 hours, beds are considered to be "available." The hospital bears the burden to exclude beds from its bed count.

King/Drew Medical Center was constructed in 1975 for more than 500 beds, and during the fiscal year at issue, the hospital was licensed for 537 beds. (pages 13 and 14 of Provider's position paper)

Some of the rooms previously used by the Provider as patient rooms were converted to use as resident and intern on-call rooms. However, as the Provider's witness testified at the hearing, the call system and other equipment were not removed from these rooms, and the rooms could be made patient available within 24-48 hours. (pages 80, 81, 82, 87 and 114 of transcript)

The Provider contends that it had a continuous legally enforceable obligation to provide space for its residents and interns who were on-call at night in the hospital, and as a practical matter did not have the ability to return the on-call rooms used by its residents to patient use. I disagree.

In his declaration, Provider witness Mr. Hernandez testified that patient care units and individual rooms were closed and/or suspended to establish space for other uses, including on-call rooms. (Provider Exhibit 11) He also testified at the hearing that the State Department of Health Services was notified that the suspended beds had been taken out of patient care services, but that "<u>they would be readily available for converting them back to patient care as required</u>." (page 111 of transcript. Emphasis added) He also stated, "When we put a bed in suspense we are telling the state that we are not admitting any patients to this room; we'll use it for an alternative purpose, <u>but we are required by law to make it converted within 24 hours, make it patient ready within 24 hours.</u>" (page 137 of transcript. Emphasis added)

The Chairperson of the Board asked Mr. Hernandez during the hearing if the Provider was representing "to the state that you can convert it (the suspended beds) back to patient use, ready for care, within 24 hours. Is that correct?" Mr. Hernandez responded, "That's correct." (page 141 of transcript)

The Intermediary maintains that the Provider's on-call rooms were used by its residents and interns solely for sleeping purposes; that no structural changes had been made in the rooms that would preclude the rooms from being made available for patient care within 24 to 48 hours; and that other rooms within the hospital were available for on-call purposes.

There is nothing so unique about Provider's on-call rooms that would have precluded them from being used for patient care, and a hospital licensed for 537 beds surely would have had other space suitable for accommodating its residents and interns during on-call duty if it had been necessary.

The Provider presented no evidence that should the need have arisen, its on-call rooms could not have been made available for patients within 24-48 hours and other arrangements made for accommodating the on-call needs of its residents and interns. In addition, as attested to by Provider's witness during the hearing, Provider was required by state law to be able to make a bed that had been put in suspense (the on-call beds) an available patient ready bed within 24 hours.

The 17 on-call beds at issue were "available beds" and should be included in the bed count used in the determination of the Provider's IME payment.

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Gary B. Blodgett

Dissenting Opinion of Yvette C. Hayes.

With all due respect to the Board majority, I find that the Intermediary improperly adjusted the number of beds included in the Provider's calculation of the IME adjustment as it relates to "storage beds". The Board's majority found that beds (in patient rooms) used for storage should be included in the number of beds available for patient care use.

The regulation at 42 C.F.R. Section 413.105(b) states in part:

> "For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period…"

The term "available beds" is not defined in the regulation, however in the preamble to the federal register…… it defined an "available bed" as (an):

> Adult and Pediatric beds maintained for lodging inpatients.

It went on further to state that:

> Beds used for purposes other than inpatient lodging….are not counted.

The term "available beds" was further defined in the Provider Reimbursement Manual (CMS Pub. 15-1, Section 2405.3G) as follows:

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It (the bed) must be available for use and housed in patient rooms or wards…"
>
> The term "available beds" as used for the purpose of counting beds is… intended to capture changes in the size of a facility as beds are added to or taken out of service.
>
> In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count."

The Board majority finds that beds (assigned to patient rooms) used for storage are still available for patient care use unless the Provider can demonstrate that the storage rooms had been modified and or altered in some manner to preclude their use for patient care.

It is this Board member's opinion that the application of this standard is not a requirement outlined in Medicare law, regulations, HCFA rulings or CMS instructions. The BCBS AB 1841, 88.01 does not have the force of law and is not even an interpretive guideline recognized by the regulations that should be allowed any deference.

The fact that any room can be put back into service is not dispositive to the question: is the bed available for inpatient lodging. If beds are taken out of service or designated for a purpose other than inpatient lodging, then that bed day should be excluded from the available bed day count because the bed is not being permanently maintained for lodging patients.

I find credible the Provider's assertion that rooms used for storage were simply unavailable for patient care because they were needed by the hospital for other purposes. Tr. at 14-15.

Testimony was offered that patient rooms were used for storage purposes principally to store patient beds, I-vac poles, patient monitors and furniture because the facility did not have a sufficient amount of designated storage space in or near the facility. Tr. at 35.

Although the Provider did also testify that these rooms *could be* put back into service for patient care by relocating the equipment to another vacant patient room and ensuring the room was patient ready safe, this assertion alone does not make the bed available for patient care but infers that it could be made ready and put into service for the lodging of patients. Therefore, this Board member finds that the bed day should be excluded from the count of available bed days until such time as the patient room is no longer deemed used for storage and the bed is placed back into service.

The beds in storage areas should not be included in the count of available bed days for the purpose of computing the proper IME payment.

Board Member

Yvette C. Hayes