PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D49

PROVIDER -
Sacred Heart Medical Center – Psychiatric
Eugene, OR

Provider No.: 38-0033

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services (f/k/a
Medicare Northwest)

DATE OF HEARING -
January 11, 2006

Cost Reporting Period Ended -
June 30, 1993

CASE NO.: 01-1010

INDEX

ISSUES:

1. Whether the exception review process engaged in by the Health Care Financing Administration[1] (HCFA) and the Fiscal Intermediary violated due process and fundamental fairness, including violations of the time limits established by federal regulation and the Provider Reimbursement Manual so as to cause the exception request to be deemed approved in full.

2. Whether HCFA and the Fiscal Intermediary improperly denied the Tax Equity and Fiscal Responsibility Act (TEFRA) adjustment in its entirety, when at a minimum Oregon Medical Professional Review Organizations (OMPRO's) independent medical review supported a reduced exception amount.

3. Whether HCFA and the Fiscal Intermediary erred in denying the Provider's revised TEFRA exception request without correcting the Intermediary's use of an incorrect TEFRA target rate.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative 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 portion 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.

From the Medicare program's inception until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually

[1] CMS was formerly known as HCFA.

incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . . " Congress ultimately amended the reasonable cost payment system because it was concerned that while being reimbursed the reasonable costs of covered services, providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs of inpatient hospital services and authorized the Secretary of DHHS (Secretary) to establish prospective limits on the costs recognized as reasonable in furnishing patient care.

In 1982 Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses such as capital-related and direct medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year.[2] However, implementing regulations at 42 C.F.R. §413.40(e) established procedures by which providers may request and receive an adjustment to or an exemption from their TEFRA target amount.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sacred Heart Medical Center (Provider) is a 470-bed acute care hospital located in Eugene, Oregon that operates a 28-bed distinct part psychiatric unit that is reimbursed under the TEFRA reimbursement methodology. The fiscal year ended (FYE) June 30, 1985 was the Provider's base year for establishing its psychiatric distinct part unit's TEFRA rate. The Provider requested and received an adjustment to its TEFRA rate in FYE 1990 from Medicare Northwest (Intermediary).[3] TEFRA adjustment requests for FYEs 1991 and 1992 were also approved. On March 5, 1996, the Provider submitted a timely request for a TEFRA adjustment for FYE 1993 pursuant to 42 C.F.R. §413.40(e)(1). The Provider employed the same methodology in applying for the TEFRA exception in FYE 1993 as it had for the exceptions that had been approved by the Intermediary and CMS for the previous years.

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[2] In 1983 Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit.

[3] Noridian Administrative Services replaced Medicare Northwest and in now the Provider's fiscal Intermediary.

The following timeline outlines the series of events and is undisputed by the parties:

- March 5, 1996 – The Provider submitted a timely exception request for a TEFRA adjustment for FYE 6/30/93 to the Intermediary.[4]
- May 3, 1996 – The Intermediary acknowledged timely receipt of the Provider's request and requested additional documentation to support the high Medicare Average Length of Stay (ALOS).[5]
- May 23, 2006 – The Provider responded to the Intermediary's request for medical records.
- June 7, 1996 – The Provider submitted a revised request for a TEFRA adjustment and notified the Intermediary that an incorrect TEFRA target rate had been applied in the cost report for FYE 1993.[6]
- April 7, 1997 – Intermediary conveyed the preliminary results of OMPRO's review to HCFA. OMPRO's preliminary results found 23 of 31 cases allowable but for a total of only 316 days.[7]
- April 18, 1997 – HCFA directed the Intermediary to tentatively deny the provider's TEFRA Exception Request.[8]
- May 13, 1997 – Intermediary notified Provider of HCFA's "tentative" denial of the 1993 TEFRA adjustment request, noting that it was not a final HCFA determination.[9]
- October 30, 1997 – OMPRO issued revised findings based upon further documentation from the Provider. OMPRO's new conclusions allowed 27 of 31 patient stays for a total of 378 covered patient days, or an ALOS of 14.00 days. The ALOS based upon dividing the 378 days allowed by OMPRO by all 31 cases was 12.19 days. These findings were not communicated to HCFA.[10]
- July 13, 1998 – OMPRO issued final findings, allowing 26 of 31 admissions for a total of 367 patient days, or an ALOS of 14.12. The ALOS for the 31 admissions and 367 covered patient days was 11.84. HCFA was not informed of the final findings.[11]
- September 28, 2000 – HCFA issued a letter to the FI concurring with Intermediary's recommendation to deny the Provider's request for a TEFRA adjustment stating that "[the Provider's] costs (in excess of the TEFRA rate) are not reasonably attributable to the circumstances specifically identified by the hospital."[12]
- October 18, 2000 – Intermediary sent out the final notice of denial of the FYE 1993 TEFRA exception request to the Provider.[13]

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[4] See, Stipulation C.4 and Provider Exhibit P-2.
[5] Exhibit P-3.
[6] See, Stipulation C.6 and Provider's Exhibit P-4.
[7] See, Stipulations D.3.p , C.9.c., and C.9.d.
[8] Exhibit I-10.
[9] See, Stipulation C.7 and denial letter at Exhibit P-5 and I-11.
[10] See, Stipulation C.11 and Provider's Exhibit P-24.
[11] See, Stipulation C.12.
[12] See, Stipulations C.8 and C.15; Provider's Exhibit P-6.
[13] See, Stipulation C.17.

- October 26, 2000 – The Provider's consultant sent a letter to the Intermediary requesting that it provide "the rationale and the information used to reach the conclusion that the clinical operations do not support the costs claimed."[14]
- January 29, 2001 – Provider filed its appeal with the Board after requesting an explanation from the Intermediary as to the rationale for the denial and not receiving a response.[15]

The Provider appealed the denial of its TEFRA adjustment request to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835 - 405.1841. The Provider was represented by Sanford E. Pitler, Esquire, of Bennett Bigelow & Leedom, P.S. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

ISSUE 1 – The Provider contends that the process engaged in by CMS and the Intermediary to review its TEFRA exception request violated well established requirements of fundamental fairness and due process, and that the Board has often applied requirements of fundamental fairness and due process to rule that CMS and its intermediaries acted inappropriately during their review of an exception request. The Provider asserts that strict time limitations are placed on each party in the TEFRA adjustment request process, and the Provider complied with every deadline while the Intermediary and CMS did not.

42 C.F.R §413.40(e)(2) requires CMS to issue a decision on the rate-of-increase ceiling adjustment request to the intermediary no later than 180 days after receipt of the completed application and the intermediary's recommendation.[16] However, CMS did not issue a final determination on the adjustment request until approximately three years after it had received the results of the Intermediary's initial medical review report for FYE 1993. The Provider contends that due to delays caused by the Intermediary and CMS and their failure to notify and allow the Provider an opportunity to respond to their findings, the Provider was significantly prejudiced, and the Board should therefore award the Provider its original TEFRA exception request in its entirety.

The Intermediary has stipulated to many of the facts in this case regarding the timeline of events, and the Intermediary agrees that the case was burdened with "serious communication breakdowns" between the Intermediary and CMS. The Intermediary nevertheless challenges the forfeit remedy the Provider is requesting because such a remedy is not available to the Provider in the law; therefore, it cannot be granted. The Intermediary acknowledges that this type of remedy is made available to providers in 42 C.F.R. §413.180(h) in the context of renal dialysis exceptions, but argues that the

[14] See, Stipulation C.18 and Provider's Exhibit P-13.
[15] See, Stipulation C.19 and Provider's Exhibit P-8.
[16] See, Intermediary's Position Paper, page 15, for admission that HCFA was the final decision maker, not the Intermediary.

controlling regulation in the instant case, 42 C.F.R. §413.40, does not include the same absolute mandate if the Intermediary or CMS does not meet its deadlines.

ISSUE 2 – The Provider asserts that incomplete and inaccurate data was relied upon by the Intermediary and CMS to deny its timely request for an exception to the TEFRA rate. It also claims that the only explanation it was given for the denial of the exception was that ". . . the above Provider's exempt unit (psychiatric) costs are not reasonably attributable to the circumstances specifically identified by the hospital."[17] The Provider asserts that it utilized the same methodology to prepare this request as it did to prepare similar requests for FYs 1990-1992, and therefore should be awarded an exception based upon that process.

Through discovery, the Provider determined that the Intermediary had submitted its TEFRA exception request to CMS with a recommendation that the request be denied. The CMS denial letter dated September 28, 2000 cited a FY 1992 TEFRA adjustment request wherein CMS indicated it "agreed with you [the Intermediary] that the discrepancies in the hospital's data warranted some type of operational review of the psychiatric unit's costs to ensure efficient operation and relatedness to Medicare beneficiaries."[18] The letter went on to say that post-payment reviews were completed in FYs 1996 and 1998 and based upon those reviews, CMS concluded that the Provider's costs in excess of the TEFRA rate were not "reasonably attributable to the circumstances specifically identified by the hospital. The hospital's clinical practices did not support costs which would justify a TEFRA adjustment."

The post-payment reviews referenced in CMS' denial letter were conducted by the Intermediary and by OMPRO. The referenced 1996 post-payment review relates to a TEFRA study completed by the Intermediary. The Intermediary issued a report on November 4, 1996 of its review of 31 claims submitted during FYE 1993.[19] The referenced 1998 post-payment review relates to a November 30, 1998 report by the Intermediary for fiscal years 1994, 1995 and 1996.[20]

The Provider claims that CMS' decision to deny the Provider's request for an exception to the TEFRA rate was based upon findings relating to years other than 1993 and to incomplete findings for FY 1993. The Provider claims that CMS was only provided the initial OMPRO findings, dated April 1, 1997 which disallowed 8 of the 31 patient admissions and allowed only a total of 316 days on the remaining 23 discharges.[21] Although OMPRO released revised findings on October 30, 1997 and its final findings on July 13, 1998 disallowing only 5 of the 31 admissions and allowing 367 patient days, the Intermediary never provided those findings to CMS.

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[17] Exhibit P-7.
[18] Exhibit P-6.
[19] Although the Intermediary issued a report on November 4, 1996, the Intermediary contracted with OMPRO to complete a more in depth review of the same 31 claims. See exhibit's I-7, I-9 and I-10 for discussion on OMPRO's additional review of the claims.
[20] Exhibit I-16.
[21] See, Stipulation C.9.c. and Provider's Position Paper, page 5.

The Intermediary and Provider have stipulated that the exception request for ALOS was denied in its entirety because the ALOS computed based on the initial OMPRO findings was 10.19 days which was less than the base year ALOS.[22] The Provider contends that the calculation utilized to arrive at an ALOS of 10.19 days was also incorrect because it was calculated using the 31 total discharges reviewed instead of the 23 discharges allowed and allowable days of 316 rather than 367. The Provider contends that this approach includes non-Medicare covered admissions in the denominator of the equation, and that this distorts the ALOS since it should only include Medicare covered admissions.[23]

The Intermediary and Provider have stipulated that there is no evidence that the final OMPRO findings were sent to CMS and agree that the determination made to deny the exception request was based on outdated data.[24] The parties have also stipulated that when applying OMPRO's final review results, the extrapolation results in an ALOS of 14.12.[25] This is greater than the base year and would therefore result in granting an adjustment to the TEFRA rate, albeit less than what the Provider originally requested. Further, the Intermediary concluded at the hearing that the exception request, as it was presented in Exhibit P-28, represented the "most accurate outcome . . . of what the proper exception amount should be."[26]

Although the Provider included in the record a computation of the exception request based upon the final OMPRO results[27] as an acceptable resolution, the Provider has also argued that the final OMPRO results themselves are flawed. The Provider asserts that the Intermediary has extrapolated the OMPRO results to the entire Medicare patient population, but no documentation was provided regarding the confidence level of the sample selection process.[28] The Provider therefore argues that since it is unclear whether the sample selection was objective or representative of the patient population as a whole, the sample's error rate should not be extrapolated to the entire Medicare patient population. The Intermediary, however, notes that the TEFRA study located at Exhibit P-21 identifies the sampling as random; therefore, the results can be extrapolated to the entire population.

ISSUE 3 – The Provider and the Intermediary have stipulated that ". . . the Intermediary approved a revised TEFRA rate for FYE 6/30/93 of $5,043.42, but the Intermediary failed to apply the revised TEFRA rate to the finalized 6/30/93 cost report."[29] The Provider requests that the Board affirm the stipulation and order the Intermediary to use the revised TEFRA rate of $5,043.42.[30]

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[22] See, Stipulation D.3.u.
[23] Provider's Position Paper, page 20.
[24] See, Stipulations C.13 and D.3.s.
[25] See, Stipulation D.3.v.
[26] Transcript, pages 167-173.
[27] Exhibit P-28.
[28] Provider's Position Paper, page 13.
[29] See, Stipulation E.3.
[30] Exhibit P-16.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and the parties' contentions, the Board finds and concludes as follows:

Issue 1 - Although 42 C.F.R §413.40(e) provides a timeframe that both parties are to follow for the request and approval or denial of a TEFRA exception, the regulation does not include language mandating approval of the TEFRA exception request if those timeframes are not met. Therefore, the Board finds no authority to grant the relief sought by the Provider, and the exception request must be decided on its merits.

Issue 2 – There is no evidence in the record that CMS was aware of the updated OMPRO findings when it denied the Provider's TEFRA exception request. The Board finds that the CMS denial was based on inaccurate and outdated medical review findings. The record supports that there was enough time and ample opportunity for CMS to obtain the final OMPRO findings and to take them into account before a decision was issued. The Board finds that the final OMPRO findings, which were issued on July 13, 1998 and produced an ALOS of 14.12, are the most accurate results on which to base a decision concerning the TEFRA exception request.

The OMPRO review results at Exhibit P-24 identify the Medicare days and discharges found allowable by OMPRO in each version of its report. OMPRO extrapolated the results from its review of 31 cases to the Provider's entire patient population to determine the ALOS. Although the Provider argues that OMPRO's review results should not be extrapolated to the universe of Medicare claims because the basis for the sample was unsupported, the Board finds that the basis of the sample was evidenced in the record. First, the Provider acknowledged in its position paper that it was informed in a telephone conference that a random number generator was used to select the sample.[31] Second, the Intermediary's TEFRA study report (Exhibit P-21) noted that the sample was chosen randomly. While the Board agrees with the Provider that the Intermediary should have been more specific regarding its sampling methodology, the Board has no reason to believe that the sample was chosen by a method other than random. Since the Intermediary's sample was random, the Board finds that extrapolation of the sample's results was proper.

The Board further finds that the Provider's calculation of the ALOS utilizing only Medicare covered admissions as the denominator and total Medicare allowable days as the numerator is the most accurate computation to determine the ALOS. The Board finds that excluding non-Medicare claims from the equation is supported by the ALOS examples included in Provider Reimbursement Manual (PRM) PRM-1 §3004.1.

The Board concludes that the TEFRA exception request as it is calculated at Exhibit P-28 and Post Hearing Exhibit-5, for increases in ALOS, increases in intensity of nursing services and increases in utilization of ancillary services, is accurate and proper, and that the TEFRA exception request in the amount of $475,830.02 should be granted.

[31] Provider's Final Position Paper, Page 13.

Issue 3 – The Board finds that the Intermediary used an incorrect TEFRA rate for the finalized 6/30/93 cost report and that the revised TEFRA rate of $5,043.42 should be used.

DECISION AND ORDER:

The Intermediary improperly denied the Provider's TEFRA rate exception request for FY 1993. An exception in the amount of $475,830.02 ($222,301.68 for ALOS, $221,685.34 for nursing intensity and $31,843.00 for ancillary services) is approved. This amount should be reduced by the incentive payment of $104,795 which has already been paid to the Provider.

The Intermediary used an incorrect TEFRA rate for the finalized 6/30/93 cost report; therefore, it should reopen the cost report and use the revised TEFRA rate.

BOARD MEMBERS PARTICIPATING:

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

DATE: July 18, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson