PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D13

PROVIDER – Fort Wayne (Indiana) FFY 2002 MSA Wage Index Group	**DATE OF HEARING -** May 25, 2011
Provider Nos.: See Attachment 1	Federal Fiscal Years - See Attachment 1
vs.	
INTERMEDIARY – Blue Cross Blue Shield Association/ National Government Services (formerly AdminaStar Federal, Inc.)	**CASE NO.:** 02-0529G

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ISSUES:

Whether the Fiscal Intermediary and the Centers for Medicare and Medicaid Services (CMS) appropriately included certain paid hours not actually worked by Parkview Health System (Parkview) employees for purposes of calculating the federal fiscal year 2002 wage index for the Fort Wayne, Indiana, Metropolitan Statistical Area (MSA).

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. *See* 42 U.S.C. § 1395 *et seq*. 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 to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs).[1] FIs and MACs determine payment amounts due the providers under Medicare law, regulations, and under interpretive guidelines published by CMS. *See*, 42 U.S.C. § 1395h and 1395kk-1, 42 C.F.R. § § 413.20 and 413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System ("PPS"). *See* 42 U.S.C. § 1395ww(d). The regulations under the PPS require a provider of inpatient hospital services to file an annual cost report based on a provider's accounting year. 42 C.F.R. § 413.20. The intermediary reviews the costs report, determines the total amount of payments owed by Medicare to the provider and issues Notice of Program Reimbursement ("NPR"). *See* 42 C.F.R. § 405.1803. Under the statute, a provider that is dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy for a single provider is $10,000 or more for an individual appeal (or $50,000 for a group); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. § § 405.1835-1837.

The PPS provides Medicare payment for hospital inpatient operating and capital related costs bases on predetermined, rates per discharge derived from average hospital costs. Those costs are divided into two parts - a labor related portion and a non-labor related portion. To account for different wage levels in the geographic areas where hospitals are located, the labor related portion is "standardized" by dividing it by the wage index applicable to each geographic area. The wage index itself is calculated by dividing the average hourly wage paid by hospitals in each area by the national average hourly hospital wage. CMS is required to update the wage index annually and bases the annual

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[1] FIs and MACs are hereinafter referred to as intermediaries.

update on a survey of wages and wage related costs taken from cost reports filed by each hospital paid under PPS. 42 U.S.C. §1395ww(d)(3). CMS publishes the wage data used to prepare the wage indices so that hospitals can review them for accuracy. If the hospital disagrees with the accuracy of the data, a hospital may request that the data be corrected and the wage index recomputed. A hospital requesting a correction must do so within a specified time limit and must provide relevant documentation to support the correction.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This Medicare Group Appeal involves the Federal Fiscal Year (FFY) 2002 hospital wage index established for the hospitals using the Fort Wayne, Indiana, metropolitan statistical wage data. During the wage index review and correction process, Parkview Health System (Provider)[2] submitted a timely request (March 8, 2001) for correction in which it asked the Intermediary to remove the paid but non-worked hours from its wage data for purposes of calculating the Fort Wayne, Indiana, MSA wage index. The Provider asked the Intermediary to describe the supporting documentation that was required to be submitted. The Provider supplied documentation for the allocation of the paid, un-worked hours. The documentation showed that all of the un-worked hours were allocated to a single department. Written instructions required the Intermediary to notify the Provider of its decision on the request no later than April 9, 2001. However, the Intermediary did not serve notice of its decision until April 10, 2001. The Provider immediately contacted CMS to obtain a review of the denial. CMS, in turn, denied the Provider's request in a letter dated May 31, 2001. The letter advised the Provider that its appeal was not timely filed by the April 9, 2001 deadline.

The parties reached a joint stipulation of the facts that summarized the issue and concluded that the cases involve no dispute over material facts. The common issue affecting the participating providers is whether the FI appropriately included certain paid hours not actually worked by Parkview Health System ("Parkview") employees for purposes of calculating the FFY 2002 wage index for the Fort Wayne, Indiana Metropolitan Statistical Area ("MSA").

The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 CFR §§ 405.1835-1841, and met the jurisdictional requirements of those regulations. The Provider was represented by Keith D. Barber, Esq., of Hall, Render, Killian, Heath & Lyman, P.S.C. The Intermediary was represented by James R. Grimes, Esq., Blue Cross Blue Shield Association.

STIPULATIONS OF THE PARTIES:

The Following are the more relevant stipulation of facts:

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[2] This decision will refer to a single provider, Parkview Health System, but it applies nevertheless to all participating hospitals in the group.

1. Parkview timely requested that certain hours related to employee paid time off ("PTO"), extended illness protection ("EIP"), and cashed-out personal time ("PER") be excluded from the calculation of its wage index.

2. When properly documented, the parties agree the hours requested by Parkview are generally excluded from the "total hours" considered for wage index calculation purposes.

3. On March 8, 2001, Parkview timely requested a correction to the FI's calculation of the hospital's wage index and included supporting documentation along with such request.

4. At the time of Parkview's request for correction, there existed no written guidance as to what constituted adequate supporting documentation for a request for an adjustment to "total hours". However, written instructions did require all providers requesting revisions to their wage data to include adequate supporting documents by the March 9, 2001 deadline.

5. The basis for Parkview's request was to remove the inclusion of 86,338 hours in the determination of Parkview's "total hours" for wage index purposes.

6. In a letter dated April 10, 2001, the fiscal intermediary notified Parkview of its refusal to make the requested correction to the FI's "total hours" determination because "(t)he response received did not have all supporting documentation as required. The data submitted as spreadsheets, etc. with no supporting records or other documentation is not acceptable."

7. The above-referenced notification from the Intermediary was the first written notice to Parkview in response to the hospital's request for correction dated March 8, 2001.

8. There exists no documentation of any kind (e-mail; phone log; facsimile; work log; or other written correspondence) to evidence any communication between Parkview and the FI occurring between March 9, 2001 and April 10, 2001.

9. On April 13, 2001, Parkview sent a letter to CMS requesting reconsideration of the FI's decision to deny the requested correction of Parkview's "total paid hours" determination.

10. On May 31, 2001, CMS sent a letter to Parkview denying Parkview's request for reconsideration. CMS set forth the following 2 reasons for such denial: 1) Parkview's request of April 13, 2001 was not timely because it should have been submitted to CMS by April 9, 2001; and 2) Parkview's original request of March 8, 2001 "lacked sufficient information."

11. The documentation currently in the record for this appeal is sufficient to support the wage index adjustments requested by Parkview.

PROVIDERS' CONTENTIONS:

The Provider contends that the controlling statute at 42 U.S.C.§1395ww(d)(3)(E) requires uniform comparison of wage levels in a geographic area with the national average wage level and argues that the comparisons in this case are not consistent because the Intermediary included non-worked hours in these indices while other areas exclude such hours.[3] The Provider argues further that consistency requires elimination of non-worked hours and offers established industry practices that exclude such hours as evidence of a standard national treatment. The Provider states that the Intermediary's inclusion of paid but un-worked hours produces a disparate treatment of employee time that understates the average hourly rate for affected hospitals.

The Provider contends that the documentation submitted contemporaneously with its March 8th request for correction was reasonable and complete based upon:

1. The guidance that it received from the FI during telephone communications that occurred between March 1 and March 8, 2001, and

2. Parkview's experience in which the FI accepted the same or similar documentation for cost report purposes.

The Provider notes that there are no written guidelines to assist providers in determining what constitutes sufficient and complete documentation in support of its requests for wage data correction. Absent such guidelines, a provider is dependent upon the intermediary for prompt notification of any deficiencies that exist in its requests for corrections. The Provider points out that the Intermediary gave no such timely notice and argues that it submitted reasonable and complete documentation to support its request for correction of data. The Provider argues that it was prejudiced by the Intermediary's failure to notify Parkview of the denial until after the deadline for the appeal had expired. The Provider believes that where there is no written guidance that establishes a standard for "sufficient and complete" support, a provider may reasonably rely upon verbal guidance from the intermediary. The Provider contends therefore, that it is arbitrary and capricious for the Intermediary to deny the request without allowing the hospital to an opportunity to provide additional documentation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary states that the corrections requested by the Provider were not adequately supported with detailed documentation. The Intermediary explains that the Provider's March 8, 2001 submission included only summary documentation in support

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[3] See: *Centra Health, Inc. v. Shalala,* 102 Fed. Supp. 2nd (W.D. VA 2000), CCH ¶300, 509 and *Sarasota Memorial Hospital v. Shalala,* 60 Fed. 3rd 1507 (11th Cir. 1995), CCH¶43,525.

of the total hours to be removed. As a result, the Intermediary was unable to reasonably conclude that the hours in question should properly be removed from the calculations.

The Intermediary argues further that the documentation requests in the record and testimony at the hearing[4] make it clear that the Provider was fully aware of the Intermediary's documentation requirements. However, the Provider simply did not think that the information was necessary and therefore did not supply it.[5]

The Intermediary contends that once the Provider submitted its revision request, the Provider should have had no reasonable expectation that the Intermediary would request anything further. CMS believes that all supporting documentation must be submitted by the correction due date (March 9, 2001) and instructed Intermediary's that they may not review any documentation that was not available to them on the due date. [6] The Intermediary does not have the responsibility to complete the provider's data submission.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law, regulations and guidelines, the parties' contentions and stipulations, and the evidence presented at the hearing, finds and concludes as follows:

The issue presented for the Board's review is whether certain paid hours but not actually worked by Parkview Health System employees were properly included in the calculations of the federal fiscal year 2002 wage index for the Fort Wayne, Indiana, metropolitan statistical area. The issue arose when the Intermediary denied a request filed by the Provider that certain hours related to employee paid time off ("PTO"), extended illness protection ("EIP"), and cashed-out personal time ("PER") be excluded from the calculation of its wage index. There is no dispute that the Provider may make such a request or that, when fully documented, such hours are properly excluded from the "total hours" considered for wage index calculation purposes.[7] The dispute in this case centers on the adequacy of the documentation supplied in support of the Provider's request.

Accordingly, the Board considered the circumstances of the Provider's filing to determine its compliance with the filing instructions. There is no dispute that, at the time of the Provider's request, the filing instructions required all providers requesting revisions to include adequate supporting documentation by the deadline but offered no written guidance on what constituted "adequate" supporting documentation.[8] Testimony at the hearing, however, indicated that both parties understood well before the deadline that the detail in the Provider's pay distribution report was necessary if the Intermediary was to verify the year end totals included in the Provider's correction request.[9] That

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[4] Transcript pp. 37-38, 41, 60.
[5] Transcript pp. 73-75.
[6] Exhibit I-18, p.2.
[7] Stipulations ¶ 4.
[8] Stipulations ¶6.
[9] Transcript, p. 60.

report was not included in the request for correction nor made available prior to the deadline.[10]

The Board notes that there was substantial discussion of informational needs between the two parties prior to the deadline[11] and that both parties understood the nature and content of the Intermediary's informational needs.[12] The Board can find no justification or mitigating circumstances for the Provider's failure to supply that information prior to the deadline. Further, 42 CFR §§ 413.20(d) establishes the accounting and record keeping standards for the maintenance of financial data and records within the Medicare program and requires that providers furnish such data "as may be needed by the Intermediary" to assure proper payment under the program. The section places an affirmative responsibility to ascertain and supply such information as may be needed by the Intermediary. Despite the apparent agreement between the parties on the nature of the information needed, the Provider failed to provide that information prior to the request for correction deadline and is, therefore, in violation of the requirement that such request be adequately documented.

The Board notes the Provider's assertion that the Intermediary had a responsibility to communicate any deficiencies in the submission to the Provider prior to denying the request. Based upon the language of the filing requirement the Board finds that the Intermediary has no such an obligation. Further, CMS policy prohibits the Intermediary from examining any documentation that was not available to it on or before the due date.[13]

DECISION AND ORDER:

The Intermediary and CMS appropriately included certain paid hours not actually worked by Parkview Health System (Parkview) employees for purposes of calculating the federal fiscal year 2002 wage index for the Fort Wayne, Indiana, Metropolitan Statistical Area (MSA).

The Intermediary's denial is affirmed.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, CPA
J. Gary Bowers, CPA
Michael W. Harty

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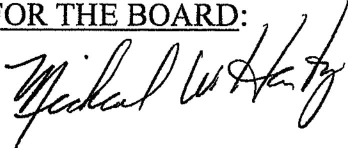
[10] Id.
[11] Transcript, p. 37-39.
[12] Transcript, p.60.
[13] Exhibit I-18, p.2.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: MAR 1 6 2012

ATTACHMENT 1

Schedule of Providers in Group (Schedule A)
Group Name: Fort Wayne MSA Wage Index Issue
PRRB Case No. 02-0529G
Group Representative: Keith D. Barber, Hall, Render, Killian, Heath & Lyman, P.S.C.
Issue: FFY 2002 Wage Index Dispute

Ex. No.	*Provider Number*	*Provider Name (City, County, State)*	*Fiscal Year(s) Ending*	*Fiscal* Intermediary*	*Date of Final Determination*	*Date of Hearing Request*	*Number of Days Elapsed*	*Audit Adjustment Number*	*Medicare Reimbursment In Dispute*	*Original Case No.*	*Date of Add/Transfer*
1	15-0017	Lutheran Hospital of Indiana *(Fort Wayne, Allen, Indiana)*	6/30/02	Admina-IN	8/1/01	1/21/02	173	N/A	217,976.00	N/A	N/A
2	15-0017	Lutheran Hospital of Indiana *(Fort Wayne, Allen, Indiana)*	6/30/03	Admina-IN	8/1/01	1/21/02	173	N/A	72,659.00	N/A	N/A
3	15-0021	Parkview Hospital, Inc. *(Fort Wayne, Allen, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	88,977.00	N/A	N/A
4	15-0021	Parkview Hospital, Inc. *(Fort Wayne, Allen, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	266,933.00	N/A	N/A
5	15-0045	DeKalb Memorial Hospital *(Auburn, DeKalb, Indiana)*	9/30/02	Admina-IN	8/1/01	1/21/02	173	N/A	27,472.00	N/A	N/A
6	15-0047	St. Joseph Medical Center-Ft. Wayne *(Fort Wayne, Allen, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	24,699.00	N/A	N/A
7	15-0047	St. Joseph Medical Center-Ft. Wayne *(Fort Wayne, Allen, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	74,099.00	N/A	N/A
8	15-0075	Caylor-Nickel Medical Center, Inc. *(Bluffton, Wells, Indiana)*	9/30/02	Admina-IN	8/1/01	1/21/02	173	N/A	42,173.00	N/A	N/A
9	15-0091	Huntington Memorial Hospital *(Huntington, Huntington, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	5,655.00	N/A	N/A
10	15-0091	Huntington Memorial Hospital *(Huntington, Huntington, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	16,966.00	N/A	N/A
11	15-0101	Whitley Memorial Hospital *(Columbia City, Whitley, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	6,994.00	N/A	N/A
12	15-0101	Whitley Memorial Hospital *(Columbia City, Whitley, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	20,982.00	N/A	N/A
13	15-0106	Adams County Memorial Hospital *(Decatur, Adams, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	7,697.00	N/A	N/A
14	15-0106	Adams County Memorial Hospital *(Decatur, Adams, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	23,092.00	N/A	N/A

Schedule of Providers in Group (Schedule A)
Group Name: Fort Wayne MSA Wage Index Issue
PRRB Case No. 02-0529G
Group Representative: Keith D. Barber, Hall, Render, Killian, Heath & Lyman, P.S.C.
Issue: FFY 2002 Wage Index Dispute

Ex. No.	*Provider Number*	*Provider Name (City, County, State)*	*Fiscal Year(s) Ending*	*Fiscal* Intermediary*	*Date of Final Determination*	*Date of Hearing Request*	*Number of Days Elapsed*	*Audit Adjustment Number*	*Medicare Reimbursment In Dispute*	*Original Case No.*	*Date of Add/Transfer*
15	15-0133	Kosciusko Community Hospital *(Warsaw, Kosciusko, Indiana)*	12/31/01	Admina-IN	8/1/01	1/21/02	173	N/A	8,533.00	N/A	N/A
16	15-0133	Kosciusko Community Hospital *(Warsaw, Kosciusko, Indiana)*	12/31/02	Admina-IN	8/1/01	1/21/02	173	N/A	25,598.00	N/A	N/A

* AdminaStar Federal, Inc. (Indianapolis, IN)

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