PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D24

PROVIDER –
Northwest Texas Healthcare System

Provider No.: 45-0209

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

DATE OF HEARING -
February 5, 2015

Cost Reporting Periods Ended -
12/31/2005 and 12/31/2006

CASE NOs.: 08-1441 and 08-2364

INDEX

ISSUE STATEMENT:

Whether the current year bed count and the available bed days were properly recorded for fiscal year ("FY") 2005, and whether the current year bed count and available bed days and the available bed days used to calculate the prior year intern to resident ratio were properly calculated for FY 2006.[1]

DECISION

The Board finds that the Medicare Contractor [2] properly calculated the number of beds and bed days for purposes of determining the IME payment for FYs 2005 and 2006. Accordingly, the Board affirms the Medicare Contractor's adjustments.

INTRODUCTION

Northwest Texas Healthcare ("Hospital" or "Provider") is a general acute care hospital that is licensed for 497 beds. The Hospital receives payments for inpatient services to Medicare beneficiaries through the Medicare inpatient prospective payment system ("IPPS"). IPPS includes a payment to certain hospitals for indirect medical education ("IME") to reflect the higher indirect costs of teaching hospitals. In accordance with regulations at 42 C.F.R. § 412.105, a hospital's IME payment is based in part on the hospital's ratio of residents to its number of beds.[3] Generally, the higher the number of beds used in the IME formula the lower the hospital's IME reimbursement.[4]

In this appeal, the Hospital disputes the number of beds that the Medicare Contractor used to calculate the Hospital's IME ratio for FYs 2005 and 2006. The Hospital timely appealed the number of beds used to calculate its IME payment to the Provider Reimbursement Review Board ("Board") and was represented at the telephonic hearing by Edward Moore, the Reimbursement Manager of Universal Health Services, Inc. The Medicare Contractor, in this case, Novitas Solutions, Inc.,[5] was represented by Brendan G. Stuhan, Esq., of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

Prior to the issuance of Notices of Program Reimbursement ("NPR") for the FY 2005 and 2006 cost reports, the Medicare Contractor toured the Hospital as part of an audit. The Medicare Contractor included an additional 10 beds in the Hospital's 3SE unit — a count of 44 beds

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[1] *See* Medicare Contractor's Post-Hearing Brief at 2; Transcript ("Tr.") at 6.
[2] Fiscal Intermediaries and Medicare Administrative Contractors are referred to as "Medicare Contractors."
[3] 42 C.F.R. § 412.105(a)(1) (2006).
[4] Provider's Final Position Papers for FYs 2005 and 2006 at Tab 1, p. 2.
[5] Mutual of Omaha and Wisconsin Physicians Services Insurance Corporation ("WPS") were the prior Medicare contractors for FYs 2005 and 2006 respectively.

instead of the Hospital's count of 34 beds.[6] The Medicare Contractor then issued the NPRs for FYs 2005 and 2006 increasing the Hospital's bed count by 10 beds.

The Medicare Contractor observed that 13 semi-private rooms were being used as private rooms. Three of the rooms had been remodeled, with oxygen hookups removed from the second bed.[7] The Medicare Contractor counted one bed for each of these remodeled rooms.[8] The Medicare Contractor counted 2 beds for each of the remaining 10 rooms because these rooms still had two oxygen hookups, two call buttons and two patient chart holders.[9] The Hospital disputes the bed count for these 10 rooms because the Hospital was only lodging one patient in each room and there was not a semi-private room charge code in the hospital's charge description master ("CDM") for these rooms.[10]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

Regulations at 42 C.F.R. § 412.105(b) describe how to determine the number of beds when calculating the IME payment. This regulation states that "the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period".[11] Subparts (1) - (6) of this regulation describe what beds should be excluded from the bed count. Subpart (2) specifically excludes beds in a unit or ward, that is otherwise occupied, that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.[12]

Further guidance on what constitute "available beds" is provided in the Provider Reimbursement Manual, Pub. 15-1, § 2405.3(G) ("PRM")[13]. The PRM states "[t]he term 'available 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." The PRM also presumes, in the absence of evidence to the contrary, beds that are available at any time during the cost reporting period are available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count."[14]

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[6] Tr.at 44:19 - 45:5. *See* Provider's Final Position Paper for 2005 and 2006, Tab P-9 at 2. Note the adjustment at issue for FYs 2005 and 2006 added 19 and 21 beds respectively; however, the Hospital confirmed during the hearing that it was only contesting the 10 beds added for the Hospital's 3SE unit. *See* Tr. at 15, 36.
[7] *See* Medicare Contractor Exhibit I-2 at 3.
[8] *Id.*
[9] *Id.*
[10] *See* Provider's Final Position Papers for FYs 2005 and 2006 at Tab 1, p. 3. Charge Master is an automated comprehensive price list of supplies, devices, medications, services, procedures, and other items for which a distinct charge to the patient exists. *See* http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047258.hcsp?dDocName=bok1_047258
[11] 42 C.F.R. § 412.105(b).
[12] 42 C.F.R. § 412.105(b)(2).
[13] *See* Medicare Contractor Exhibit I-7 at 9.
[14] *Id.*

In the preamble of the 2005 Final Rule ("Final Rule"), CMS reiterated that "[o]ur current policy is intended to reflect a hospital's available bed count as accurately as possible, achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity."[15] In the preamble to the Final Rule, CMS clarified that "if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, the unoccupied bed is determined available."[16] CMS further explained that:

> [I]n order for any bed within a unit or ward that would otherwise be considered occupied to be excluded because it is unavailable, the bed must remain unavailable for 30 consecutive days. In other words, if an individual bed or group of beds within an otherwise occupied unit or bed could not be made available within a 24-hour period, for whatever reason (for example, renovations, use as office space, use for provision of ancillary services) for 30 consecutive days, the beds should be excluded from the hospital's available bed count for those 30 consecutive days. This policy would apply to all situations that would render a bed unavailable, not just to the examples listed above.[17]

Due to a severe nursing staff shortage in Amarillo, Texas, the Hospital contends that the 10 disputed beds in the 3SE unit should not be considered available beds because the beds could not be staffed within 24 hours with either employed or contracted personnel.[18] The Hospital further contends that these beds should not be counted because a second bed has not been used in these rooms for approximately 5 to 6 years, a second bed is not actually in these rooms, and there is no mechanism in place to charge for the second bed in these rooms as the Hospital's CDM has these rooms listed as private rooms.[19] Finally, the Hospital asserts that, if it was functioning at 100 percent capacity, it would not restore a second bed to these ten rooms but rather, direct patients to another acute care facility.[20]

The Board finds that PRM § 2405.3(G) imposes the burden on the Hospital to prove that the beds should be excluded from the count and that the Hospital was obligated to provide sufficient information to the Medicare Contractor to demonstrate that the disputed beds could not be staffed within 24-48 hours or that these beds were unavailable and could not be made available within a 24-hour period. The Board finds that the Hospital has not met its burden. Specifically, the record contains two similar statements from nursing staff that "[a] shortage of staff and the unavailability of nurses from nurse registries severely constrained census and did not allow the unit to operate at bed capacity…"[21] The record also includes another statement, signed by the

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[15] *See* 69 Fed. Reg. 49093, 49094, 49096 (Aug. 11, 2004). *See* Medicare Contractor Exhibit I-6.
[16] 69 Fed. Reg. at 49094.
[17] *Id.* at 49095.
[18] *See* Provider's Final Position Papers for FYs 2005 and 2006 at Tab 1, p. 3; Tr. at 48:2-8.
[19] *See* Provider's Final Position Papers for FYs 2005 and 2006 at Tab 1, p. 3.
[20] *Id.*
[21] *See* Provider's Final Position Papers for FYs 2005 and 2006 P-9 at 16, 17.

hospital's Chief Nursing Officer, that a nurse staffing agency, with whom the hospital contracted, was unable to deliver sufficient staffing to support a higher patient volume.[22]

These statements are insufficient to support the Hospital's position that the beds could not be staffed within 24-48 hours. The Hospital provided neither evidence that corroborates these claims (*e.g.* that the contracted nursing agency could not fill requests for staff) nor evidence that the Hospital was advertising or otherwise seeking to fill its staffing needs. In short, the Hospital has provided no independent documentation confirming that there was a shortage of nurses in the area during the entire time period that the Hospital claims the beds were unavailable.[23]

Further the Board finds that, with appropriate staffing, the 10 disputed beds could be put in service within 24 hours. The Board supports this conclusion based on the fact that each of the 10 rooms that the Hospital contends are private rooms contains two oxygen connections, two patient chart holders and two nurse call buttons.[24] This evidence shows that these 10 private rooms could have been converted into semi-private rooms by simply wheeling in a bed from storage or elsewhere and connecting it to the existing connections.[25]

The Board observes that the Hospital permanently took some of its licensed beds out of service by removing the second set of hookups from the room or converting rooms to conference rooms or offices. These beds were not disputed by the Medicare Contractor.[26] However, for the 10 beds in dispute, the Hospital did not remove the second set of hookups. The Hospital could have simply moved beds back into the rooms in a short period of time. This evidence is sufficient to demonstrate to the Board that the Hospital did not intend to take these 10 beds permanently out of service. The Board points out where the oxygen hookups were removed, the Medicare Contractor agreed that those beds could not be put into service and excluded those licensed beds from the bed count.[27]

Finally, the Hospital argues that the disputed beds should be excluded from the bed count because the hospital does not have a way to charge them using its CDM.[28] The Board cannot find any regulatory or policy support for the Hospital's position that its CDM is relevant to determine the number of available beds.[29]

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[22] *See* Provider's Final Position Paper for 2006 P-9 at 18.
[23] The record shows that prior to the hearing, the Medicare contractor asked the Hospital for specific types of documentation corroborating the attestations and documenting the claimed staffing limitations, but the Hospital failed to respond to this request. *See* Medicare Contractor Exhibit I-8.
[24] *See* Medicare Contractor's Post Hearing Brief at 5.
[25] During the hearing, the Hospital's Representative could not confirm whether there was any reason that the rooms could not be occupied if nurse staffing was not an issue. Tr. at 45-46.
[26] *Id*.
[27] *See* Medicare Contractor's Post Hearing Brief at 6.
[28] *See* Provider's Final Position Papers for FYs 2005 and 2006 at Tab 1, p. 3; Tr. 9:10-21.
[29] Similarly, the Hospital's statement that it would not add the second bed to those rooms if it were at 100 percent capacity is not relevant because the standard is whether the second beds could be made available within 24 to 48 hours.

DECISION AND ORDER:

The Board finds that the Medicare Contractor properly calculated and recorded the number of beds and bed days for purposes of determining the IME payment for FYs 2005 and 2006. Accordingly, the Board affirms the Medicare Contractor's adjustments.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 16, 2015