PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D51

PROVIDER -
The Aroostook Medical Center
Presque Isle, Maine

Provider No.: 20-0018

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Associated Hospital Services of Maine
(n/k/a National Government Services-
Maine)

DATE OF HEARING -
February 8, 2006

ESRD Closing Window -
August 30, 2000

CASE NO.: 01-0883

INDEX

ISSUE:

Was CMS' denial of the end stage renal disease composite rate exception request correct based on applicable Medicare law?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

On remand by the United States District Court for the District of Maine,[1] a hearing was held for the purpose of taking the testimony of Mr. Michael Nobile, formerly a senior auditor with Associated Hospital Services of Maine, the Medicare fiscal intermediary (Intermediary). The District Court ruled that the Provider Reimbursement Review Board (Board) abused its discretion in failing to issue a subpoena directing Mr. Nobile to appear for testimony at the original March 17, 2003 hearing, as such testimony was necessary to ensure a full and complete record of all the facts and issues in this appeal. Accordingly, on February 8, 2006, the Board held a telephonic hearing to consider Mr. Nobile's testimony.

Aroostook Medical Center (Provider) is a general acute care hospital located in Presque Isle, Maine, that provides dialysis services to patients with end stage renal disease (ESRD). This case concerns the Centers for Medicare and Medicaid Services' (CMS)[2] denial of the Provider's application for relief from the composite payment rate established for its Medicare-certified renal dialysis facility. Pursuant to the provisions of §1881(b)[3] of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq., ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system. Under this system, a provider of dialysis services receives a prospectively determined payment for each dialysis treatment that it furnishes. An ESRD facility must accept the composite prospective payment rate established by CMS as payment in full for covered outpatient dialysis. During certain periods of time referred to as "exception windows," an ESRD provider may request an exception to its composite rate in accordance with the procedures established under 42 C.F.R. §413.180. Such an exception window was opened by CMS commencing on March 1, 2000. The Provider filed an exception request based on its claim that it met the exception criteria as an "isolated essential facility (IEF)."

The Intermediary reviewed the Provider's request, concluded that the Provider was "isolated," "essential," and that its cost per treatment was reasonable and related to the isolated essential facility criteria. Accordingly, the Intermediary recommended a composite rate of $218.97,[4] or an increase of $96.35 per treatment.

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[1] Aroostook Medical Center v. Leavitt, 365 F.Supp. 2d 51 (D.Me. 2006).

[2] Previously called Health Care Financing Administration (HCFA).

[3] 42 U.S.C. §2395rr.

[4] Intermediary Exhibit (Ex.) 2. Intermediary's recommended rate $218.97 minus composite rate of $122.62 = $96.35/treatment. See, Provider's post-hearing brief at 2.

CMS, did not follow the Intermediary's recommendation and denied the exception request on the basis that the Provider failed to justify its costs and relate them to the IEF criteria.[5] The Provider filed a timely request for a hearing before the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

The Board initially heard this case on March 17, 2003. Prior to the hearing, the Provider requested a subpoena for the testimony of Mr. Nobile, the Intermediary employee responsible for reviewing the Provider's exception request. The Provider also requested a subpoena for all records and materials that Mr. Nobile reviewed, consulted, or prepared during his review of the exception request. The Board denied the subpoena request on the basis that Mr. Nobile did not make the final decision as to whether the Provider was entitled to an exception.

On June 9, 2004, the Board issued its decision affirming CMS' denial of the Provider's exception request on the basis that the Provider failed to provide a copy of its latest cost report and a listing of patients by modality showing distance and time to the current and next nearest renal dialysis facility as required by 42 C.F.R. §413.186. The Board also found that the Provider failed to document that costs in excess of the composite rate related to the essential facility criteria of 42 C.F.R. §413.186. The CMS Administrator subsequently declined to review the Board's decision.

The Provider appealed the Board's decision to the United States District Court for the District of Maine and on April 13, 2005, the Court issued an order[6] vacating the decision and remanding the case to the Board for further proceedings. The Court noted that the Board abused its discretion in failing to issue a subpoena for Mr. Nobile to appear at the Board hearing with the documents he considered as such documents and testimony were relevant; and, accordingly, the Provider was deprived the opportunity to present a full and complete argument to the Board.

On February 8, 2006, the Board held a telephonic hearing pursuant to the District Court order and the Deputy Administrator's remand order. The Provider was represented by William H. Stiles, Esquire, of Verrill and Dana, LLP. The Intermediary was represented by Arthur Peabody, Esquire, of Blue Cross Blue Shield Association.

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[5] Intermediary Ex. 3.

[6] Supra, note 1.

PROVIDER'S CONTENTIONS[7]

The Provider notes that Mr. Nobile testified that he recalled reviewing and sending the cost report, workpapers and documents to CMS with his favorable recommendation, and neither the Intermediary nor CMS disputed his testimony. Additionally, the Provider contends that the CMS denial letter[8] clearly indicates that CMS limited its review to the Provider's request and did not consider the attachments that Mr. Nobile forwarded to CMS.

The Provider states that because the Intermediary forwarded the cost report to CMS, the Board should not deny the ESRD application on the mere technicality that the Provider failed to include the full cost report with its original request. The fact that Nr. Nobile could not recall how he obtained the cost report is unimportant. The Intermediary may have requested the report from the Provider or it may have obtained a copy of the as-filed cost report from its own files.

Additionally, denying the exception request based upon incomplete mileage information exalts form over substance. The Intermediary could have performed elementary arithmetic to conclusively determine that if the Provider closed its facility, a substantial number of the Provider's patients could not obtain dialysis services in Aroostook County without additional hardship.

Moreover, the Provider argues that CMS should not benefit from the fact that the Intermediary and CMS have apparently misplaced Mr. Nobile's workpapers. It is well established that when documents relevant to litigation are destroyed or not produced by a party, the fact finder may draw an adverse inference that the documents contained information damaging to that party, as long as that party had some reason to know of the documents' relevance at the time of their loss.[9] The adverse inference that should be drawn is that the missing information would have conclusively shown that the information submitted by the Provider and considered by the Intermediary satisfied all of the Provider Reimbursement Manual (P.R.M.) criteria for an increased composite rate.

Additionally, the Provider states that the Intermediary and CMS were on notice that they were obligated to preserve the Intermediary's file. 42 U.S.C. §1395oo(d) requires that a

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[7] The summaries of the parties' contentions herein summarize the arguments presented relating to Mr. Nobile's testimony at the February 8, 2006 hearing. Both parties requested that the Board also consider, by incorporation, the arguments presented during the original hearing. Accordingly, to summarize the parties' original positions, we have incorporated into this decision as Exhibit A a copy of the June 9, 2004 decision which has been vacated. The Board, in issuing the present decision, has reconsidered both the evidence and arguments which were presented in the original hearing as well as the supplemental evidence and materials presented at the February 8, 2006 hearing.

[8] Supra, note 5.

[9] The Provider cites Nation-Wide Check v Forest Hills Distributors, 692 F.2d 214, 217-18 (1st Cir. 1982).

decision by the Board reviewing an Intermediary [or CMS] decision "shall be based upon the record made at such hearing, which shall include the evidence considered by the Intermediary..." Likewise, P.R.M. §2724 specifically requires CMS to review the entire submission from the Provider.[10] Finally, the District Court stated that "Mr. Nobile's testimony, and the documents considered by the Intermediary, are highly relevant . . . ." (emphasis added)[11]

INTERMEDIARY'S CONTENTIONS:

The Intermediary requests that the Board reinstate its prior decision because even after considering Mr. Nobile's testimony, the Provider still failed to establish that it met the two objective requirements of 42 C.F.R. §413.186(c)(4); namely, to provide a copy of its most recent cost report and a listing of patients by modality showing commuting distance and time to the current and next nearest renal dialysis facility

Alternatively, the Intermediary disagrees with the Provider's contention that because the cost report pages at issue were available during the auditor's review, the regulatory requirement to furnish the cost report with the exception request is negated. The Intermediary contends that documents or information not provided with the exception request may not be considered in accordance with 42 C.F.R. §413.194(c)(2). As such, Mr. Nobile's testimony regarding what, if any, parts of the cost report were reviewed is irrelevant.

Second, the Intermediary notes that Mr. Nobile could not precisely recall what he reviewed; rather, he recalled only looking at certain costs.[12] The witness had only the most general recollection of reviewing the cost report and he could not recall how he received it.[13] Significantly, he could not recall whether he reviewed information displayed on Worksheet S-5 or even what information is set forth on that worksheet -- essential information about an ESRD facility.[14]

Third, Mr. Nobile testified that this was the first ESRD exception request that he had reviewed.[15] The Intermediary argues that his testimony that the application met all the regulatory requirements, especially when it is clear that objective requirements were not met, is therefore entitled to little weight.

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[10] P.R.M §2724 states, in relevant part, "Upon receipt of the exception request information from the intermediary, CMS: reviews all the information submitted; prepares a decision based on the documentation submitted and advises the intermediary of the decision or the status of CMS's review; and notifies the intermediary of any exceptions to the facility's rate…."

[11] Supra, note 1 at 57.

[12] Intermediary's Supplemental Post-Hearing Brief at page 4. Tr. at 40-43.

[13] Tr. at 31.

[14] Tr. at 42.

[15] Tr. at 27.

Fourth, the Intermediary characterizes Mr. Nobile's testimony conflicting as to whether his review of the exception request was thorough. Although he testified that he conducted a thorough review, he sent a letter to the Provider at the time of the review indicating that it was cursory.[16]

Also, regarding the Provider's argument that the Intermediary could make simple mathematical calculations to reach the time and distance of patients from their residence to the next nearest facility, such argument cannot stand given the objective regulatory requirement that such information be provided with the exception request and the unreliability of the information disclosed on the face of the list, as highlighted by Mr. Nobile's testimony.[17] Although the Provider argues that the Intermediary could have computed the distances at issue, Mr. Nobile was unable to explain various irregularities contained on the list such as the identification of some patients as Maine residents even though they listed out of state addresses.[18] The Intermediary argues that no reasonable auditor would use such information as a basis for other calculations as the Provider suggests. Moreover, the Intermediary is under no duty to recalculate such data, especially where, as here, the Intermediary received the Provider's request just prior to the deadline; *i.e.*, on August 24, 2000 only 6 days before the close of the window.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

42 C.F.R. §§413.180(f)(1999)[19] and 413.184(c)(iv)(1999) explicitly require a provider that seeks an exception based upon the IEF criteria to file a copy of its latest cost report to support its request. Additionally 42 C.F.R. §413.186(c)(4)(vii)(1999) requires that such a provider file "a list of patients by modality showing commuting distance and time to the current and the next nearest renal dialysis facility."

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that Mr. Nobile's testimony does not alter the Board's June 9, 2004 ultimate findings.[20] There remains no conclusive evidence that the Provider filed the requisite cost reports[21] with its exception request. Mr. Nobile's recollections[22] of reviewing sections of the cost report do not relieve the Provider from filing its request in compliance with the regulations.

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[16] See Ex. P-9, Tr. 40-41
[17] See Tr. at 46 et seq.
[18] See, Intermediary Hearing Book, Exhibit I, HB3 pg. 42. Tr. 45-48. Mr. Nobile conceded that the column on the relevant page of the application entitled, "Mileage to the Next Nearest Facility," was blank. Tr. at 45-48.
[19] The Board notes that the controlling regulations in this case are the versions in effect on August 22, 2000, the date on the Provider's exception request.
[20] See Exhibit A (attached).
[21] See Tr. at 31.
[22] See Tr. at 41-42.

Likewise, it remains undisputed that the Provider failed to submit a listing of commuting times and distances to the next nearest facility. Although the Provider claims that this information can be calculated by the Intermediary, a careful look at the addresses of the patients, at the very least, raises additional questions about the accuracy and reliability of the data provided. However, regardless of the quality of such information, the Provider failed to submit the information in the manner required by the regulations.

Finally, while the Board notes that the Court opined[23] that a denial based on the Provider's failure to submit adequate documentation regarding commuting distances "borders on arbitrary and capricious" and is "a matter of form over substance," the Board does not have the equitable powers to ignore the explicit regulatory requirements.[24] The Board also notes that while it is unfortunate that the Intermediary was unable to locate its workpapers, this is not a controlling factor in the final analysis.

DECISION AND ORDER:

CMS properly denied the Provider's exception request.

BOARD MEMBERS PARTICIPATING:

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

DATE: July 25, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

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[23] Supra, note 1 at footnote 14.

[24] 42 C.F.R. §405.1867 states "Sources of Board's authority. In exercising its authority to conduct the hearings described herein, the Board must comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator of the Centers for Medicare and Medicaid Services (see §401.108 of this subchapter). The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."