PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D84

PROVIDER -
St. Luke=s Memorial Hospital
Racine, Wisconsin

Provider No. 52-0094

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross Blue Shield United of Wisconsin

DATE OF HEARING-
May 16, 2000

CASE NO. 95-0711

INDEX

ISSUE:

Did the Health Care Financing Administration (AHCFA@) inappropriately deny the Provider=s end stage renal disease (AESRD@) composite rate exception request for atypical service intensity (patient mix) on the grounds that the Provider did not file a fully documented exception request?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Luke=s Memorial Hospital (AProvider@) is a 230-bed, non-profit, general, acute care hospital located in Racine, Wisconsin. The Provider also operates a renal dialysis facility that offers a variety of ESRD services which include outpatient maintenance and inpatient hemodialysis, continuous cyclic peritoneal dialysis (ACCPD@) and continuous ambulatory peritoneal dialysis (ACAPD@). CCPD and CAPD are home dialysis modalities. In October of 1993, HCFA issued a Program Memorandum to Medicare Intermediaries entitled AReopening of the Exception Process under the End Stage Renal Disease (AESRD@) Composite Rate System.@[1] Pursuant to the Program Memorandum, HCFA reopened the process for ESRD facilities seeking an exception to the ESRD composite payment rate effective November 1, 1993. The period for filing an exception request (Awindow@) was open from November 1, 1993 to April 29, 1994.

The Provider submitted an exception request to Blue Cross Blue Shield United of Wisconsin (AIntermediary@) on April 29, 1994,[2] which was the last day for filing an exception request under the Awindow@ establish by HCFA. By letter dated May 17, 1994, the Intermediary transmitted the Provider=s exception request to HCFA with its recommendation that an exception rate of $146.47 be approved for atypical service intensity.[3] The Provider=s composite rate at the time of the request was $123.01. On July 18, 1994, HCFA informed the Intermediary that the Provider=s exception request was denied.[4] In denying the Provider=s request, HCFA cited the following reasons:

> The narrative documentation and financial data submitted with this exception request for fiscal years (FY) 93, 94 and 95 indicated that SLMH [St. Luke=s Memorial Hospital] has a sizeable home program. Section 2702 of the Provider Reimbursement Manual (PRM) states that

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1 See Intermediary Exhibit I-1.

2 See Intermediary Exhibit I-2/ Provider Exhibit P-1.

3 See Provider Exhibit P-12. Note - The Provider=s application also requested an exception based on its qualification as an isolated essential facility (AIEF@). The Provider has withdrawn this portion of its exception request as an issue in this appeal.

4 See Provider Exhibit P-13/Intermediary Exhibit I-3.

> a facility=s composite rate is a comprehensive payment for all modes of in-facility and home dialysis. Therefore, in determining an exception under the composite rate, we take into account the home program along with the maintenance program. Since SLMH did not account for its home program patients when filing this composite rate exception request, it has not filed a fully documented exception request. Therefore, SLMH=s exception request is denied.
>
> It is the responsibility of the provider to file a fully documented exception request. Further, SLMH should be advised that the burden of proof for justifying an exception request rests with the provider not HCFA nor its intermediary [See 42 C.F.R. ' 413.170 (f) (5)].
>
> Since SLMH has not filed a fully documented exception request, this office did not make a decision regarding the two exception criteria. Also, this office did not prepare a cost analysis nor a cost per treatment analysis.

HCFA Denial Letter of July 18, 1994.

In addition, HCFA made other comments regarding the Provider=s exception request which included the following:

> SLMH did not furnish its projected budgeted cost reports for FYs 94 and 95 on the appropriate cost reporting schedules as required by section 2721.F of the PRM.

Id.

The Provider appealed HCFA=s determination to the Provider Reimbursement Review Board (ABoard@) and has met the jurisdictional requirements of 42 C.F.R. ' 413.170 (h) and 42 C.F.R. '' 405.1835-.1841. The Intermediary estimated the amount of Medicare reimbursement in controversy to be approximately $426,000. The Provider was represented by Daniel F. Miller, Esquire, and Leslye A. Herrmann, Esquire, of von Briesen, Purtell and Roper, s.c. The Intermediary=s representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that it meets the requirements for an exception to its ESRD composite rate based on atypical service intensity as provided for under 42 U.S.C. '1395rr(b). Pursuant to the statute, the regulations at 42 C.F.R. ' 413.170 (f) set forth the procedures for requesting an exception as follows:

> If requesting an exception to its payment rate, a facility must submit to HCFA its most recently completed cost report as required under '413.174, and whatever statistics, data, and budgetary projections are determined by HCFA to be needed to determine if the exception is approvable. HCFA may audit any cost report or other information submitted. The materials submitted to HCFA must!
>
> (i) Separately identify elements of cost contributing to costs per treatment in excess of the facility=s payment rate;
>
> (ii) Show that all of the facility=s costs including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;
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> (iii) Show that the elements of excessive cost are specifically attributable to one or more conditions specified by the criteria set forth in paragraph (g) of this section; and
>
> (iv) Specify the amount of additional reimbursement per treatment the facility believes is required in order to recover its justifiable excess costs.

42 C.F.R. ' 413.170 (f)(6).

Th Provider notes that the Intermediary=s review of the exception request did not find a documentation problem. However, HCFA rejected the request based on its determination that the Provider did not account for its home program patients. The Provider asserts that it furnished all of the requested information required under the manual instructions, including the data required for home patients. Accordingly, HCFA had sufficient data to conclude that the Provider had a sizeable home program. However, HCFA chose to ignore that data and rely instead on the ambiguous statement in the narrative

to conclude that the request did not account for the home program patients. Based on the home program data included in the financial information and referred to in the narrative, the HCFA reviewer of the exception request should have understood that the patient information would have included the home program as well.

The Provider believes that the information included in the original exception request demonstrated that it is entitled to an adjustment to its composite rate. Nevertheless, in an attempt to anticipate HCFA=s analysis, the Provider revised its rate calculation chart to include the home population. Although the Provider asserts that HCFA had all of the information it needed to revise the requested rate calculation to include the home population, the Provider believes its revised calculations included in Provider Exhibit P-15A demonstrate that a simple recalculation could have been completed by HCFA to incorporate the home population. Given that all necessary data was included with the exception request, and that HCFA had provided no guidance as to how to make its exception rate calculation, the Provider argues that HCFA=s failure to perform the necessary calculations was arbitrary and capricious.

The Provider further contends that the Provider Reimbursement Manual (AHCFA Pub. 15-1@) provides no guidance regarding how a provider should calculate its adjustment to the composite rate. The instructions at HCFA Pub. 15-1 ' 2721.D merely require the facility to list the current and requested payment rate for each modality of treatment. No instructions are provided for how to calculate the new hemodialysis and peritoneal dialysis rates, and the instructions do not require facilities to include all modalities of treatment in one exception rate request calculation. Relying on this manual provision, the Provider argues that it was reasonable to only request an exception rate for hemodialysis, which necessarily excludes the CCPD and CAPD home patients. Since the Provider believed that a higher rate attributable solely to the home patient population would not have been warranted in this case, the Provider contends that it took a reasonable approach to the calculation given the limited manual instructions. In the absence of specific instructions, the Provider met its burden in documenting its exception request, and HCFA should not be permitted to summarily reject the Provider=s approach for an alleged failure to predict what methodology HCFA would devise.

The Provider alternatively argues that, if it was required to include the home dialysis population in its rate calculation, it was arbitrary and capricious of HCFA not to make the very minor calculation that would have been needed to revise the Provider=s exception request. In support of this argument, the Provider refers to its Exhibit P-15A which shows that recalculating the rate was a simple task and within HCFA=s purview. The Provider further contends that HCFA is required to consider the entire request where it determines that the analysis and calculations should include additional information. In this regard, the Provider cites the Board=s decision in The Christ Hospital v. Blue Cross and Blue Shield Association/AdminaStar Federal, Inc., PRRB Dec. No. 2000-D8, December 8, 1999, Medicare and Medicaid Guide (CCH) & 80,383,[5] rem=d. HCFA Admin., Feb. 11, 2000, Medicare and Medicaid

[5] See Provider Exhibit P-17.

Guide (CCH), & 80,416,[6] (A Christ Hospital@). In that case, HCFA had limited its review to only three pages of the narrative, and failed to consider data on the provider=s home dialysis patients that had been included throughout the exception request. The Board held in Christ Hospital that the home dialysis information in contention was readily available and that, by HCFA limiting its review of the provider=s exception request, it had improperly denied the provider=s request for an exception to the ESRD composite rate. While the Administrator overturned the Board=s granting of the exception request, the Administrator found that the record demonstrated that the home dialysis patients were included in the exception request, and remanded the case to HCFA with instructions that the data be examined. Accordingly, the Provider concludes that HCFA=s analytical role in reviewing exception requests should not be limited to looking for errors, and summarily denying requests without considering their substance. In the instant case, HCFA appears to have limited its review to one statement (i.e., the Provider=s apparent misstatement that it has no home population), and ignored the information that was clearly available throughout the remainder of the exception request.

It is the Provider=s position that the Board has the authority to consider a revised calculation where the revision uses only data that was provided with the exception request. The Provider is aware that the appeal provisions in 42 C.F.R. ' 413.170(h)(3)(ii) preclude the submission of additional information or cost data to the Intermediary or the Board that were not submitted to HCFA at the time the facility requested an exception to its prospective payment rate. The Provider asserts that it did not violate this requirement by incorporating the information relating to the home dialysis patients in its revised calculation provided at Exhibit P-15A because the data utilized was submitted with the initial exception request. The Provider argues that the bar on consideration of new information or cost data was not intended to be used to prevent a provider from revising a calculation, but was introduced by HCFA to prevent the use of cost data gathered from periods after the exception request was submitted. The Provider points out that when HCFA introduced the regulatory provision as a final rule, its meaning was explained as follows:

> When a facility appeals its exception determination to the PRRB [Board], it will not be permitted to submit cost information that was not included in the documentation supporting its exception request. Under a prospective system, it would be inconsistent to consider cost experience occurring after an exception is requested. If such cost experience were accepted in an appeal of an exception determination, it could have the effect of undermining the prospective system and its incentives by basing a facility=s payment rate on costs for the period to which the rate applied. This would introduce a strong element of

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[6] See Provider Exhibit P-21.

> retrospective cost settlement which would be inconsistent with the intent of Congress.

48 Fed. Reg. 21254, Section II.C.4 (May 11, 1983).

Consistent with HCFA=s intention, the Provider is not requesting that the Board consider any cost information or experience that dates from after the exception request. Accordingly, the Provider concludes that the revised calculations provided in Exhibit P-15A may be considered by the Board. Based on the recalculated rate request set forth in Exhibit P-15A, the Provider contends that it is entitled to an exception rate of $143.29 (the $123.01 composite rate plus the $20.28 attributable to atypical service intensity). This recalculation includes the information relating to the Provider=s home dialysis program, including adjustments to the home program numbers of treatments to account for the fact that home dialysis is paid at the daily rate of 3/7th of the composite rate for in-facility outpatient dialysis. As demonstrated by the annotations set forth on Exhibit P-15A, all of the information used for the recalculated rate request was present in the original exception request. Accordingly, the Provider requests that the Board grant an exception rate in the amount of $143.29. While the HCFA reviewing official who testified at the hearing suggested that the methodology applied in Exhibit P-15A is not the method used by HCFA in calculating exception request rates,[7] the Provider notes that HCFA has not published any specific methodology for calculating the exception rate. The various approaches suggested by the HCFA witness for calculating the rate should not be elevated to the level of guidance and applied to the Provider in this forum. Given that such unrecorded policies would be applied to the Provider=s exception request should it be remanded to HCFA, the Provider requests that the Board grant its reasonably derived exception rate to avoid the application of undocumented policies, and the lengthy further appeal process that will result therefrom.

The Provider further contends that it would be arbitrary and capricious for HCFA to deny the exception request based on its failure to use the cost reporting forms. In its denial letter, HCFA commented that the Provider did not furnish its projected budget report for fiscal years 1994 and 1995 on the appropriate cost reporting schedules as required by HCFA Pub. 15-1 ' 2721.F.[8] Although HCFA did not rely on this comment in denying the Provider=s exception request, the Provider argues that HCFA should not be allowed to elevate this supposed deficiency into a basis for denial. Moreover, HCFA did not contend that the information contained budget predictions that were incorrect, unreasonable, difficult to understand and analyze, or inconsistent with an actual cost reporting form. Accordingly, the denial of the Provider=s request for not using a computer-generated cost report would be the ultimate elevation of form over substance. The Provider asserts that it complied with the applicable requirements of 42 C.F.R. ' 413.170 (f)(6) and (g)(1), which make no reference that budget estimates must be submitted on any particular form.

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[7] Tr. at 188-195.

[8] See Provider Exhibit P-13 at 2.

With respect to HCFA=s reliance on the manual instructions, the Provider points out that HCFA Pub. 15-1 ' 2721.F requires only that:

> ...The documentation to support the projected budget estimate must be submitted in the following format:
>
> C Appropriate, completed cost reporting schedules; i.e., Supplemental Worksheets I-1, 2 and 3 of Form HCFA - 2552(hospital-based facilities) or Form HCFA-265 (independent facilities) full cost report listing the projected budget costs;...

HCFA Pub. 15-1 '2721.F

The Provider believes that a reasonable reading of this language would be that the word Aformat@ suggests that the budget estimates submitted should be in the format of, or look substantially like, the supplemental worksheet described. The use of the exact form itself is not clearly stated in the manual instructions. Further, the creation of supplemental worksheets using the computer program that generates an actual cost report is impracticable because certain information can only be generated by filling out a substantial portion of the entire hospital cost report. The Provider argues that this would be a huge and futile exercise for the sole purpose of submitting an exception rate request. In addition, the Provider notes that both the Board and the D.C. District Court have rendered decisions which support this interpretation. The Provider cites the Board=s decision in University of California v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D18, January 25, 1995, Medicare and Medicaid Guide (CCH) & 43,051, rem=d. HCFA Admin., March 26, 1995, wherein the Board accepted handwritten calculations correcting a worksheet in the as-filed cost report. The Administrator remanded the matter to HCFA finding that HCFA was required to consider the handwritten corrections even though they did not conform completely with the routine reporting requirements. As to the D.C. Court=s decision in Mercy Hospital of Miami, Inc. v. Shalala, Case No. 91-3268 (D. D.C. Sept. 13, 1993),[9] the court noted that under 42 C.F.R. ' 413.170(f)(6); AA provider need submit documentation on top of >its most recently completed cost report= only when HCFA determines that such would >be needed to determine if the exception is approvable.= Under the regulations, therefore, absent specific notice from HCFA, a provider=s duty is discharged once it has submitted its most recently completed cost report along with its exception request.@ The Provider concludes that HCFA=s use of the word Aformat@ does not qualify as the Aspecific notice@ that the D.C. court has stated is necessary in order for HCFA to add documentation requirements to 42 C.F.R. ' 413.170(f)(6).

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[9] See Provider Exhibit P-16.

It is the Provider=s conclusion that the Board should find that its exception request was properly filed with sufficient supporting documentation, including the calculation at Provider Exhibit P-15A. Accordingly, the Board should grant the Provider=s request for an exception amount of $20.28, so that its revised dialysis rate is $143.29.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that HCFA properly denied the Provider=s exception request based on its determination that the Provider=s submission was not fully documented as required under the governing regulatory and manual provisions. Pursuant to 42 U.S.C. '1395rr(b) and 42 C.F.R. '413.170 et seq., a hospital-based ESRD facility receives Medicare reimbursement on the basis of a Acomposite rate system@ whereby a prospectively determined payment amount is paid for each dialysis treatment. The ESRD facility must accept the established payment rate as payment in full for the covered outpatient maintenance service. However, the statute at 42 U.S.C. '1395rr(b)(7) also directs the Secretary to allow for provider exceptions to the prospective payment rate where unusual circumstances may warrant. The implementing regulations at 42 C.F.R. ' 413.170(f) and (g) set a procedure and criteria under which facilities may seek relief from their composite rate. The exception process is further clarified in the instructions set forth under HCFA Pub. 15-1 ' 2720 et seq.

In accordance with the governing regulations and manual instructions, an ESRD facility may obtain an exception if it can demonstrate with convincing objective evidence that its allowable cost per treatment is reasonable and will exceed its prospective payment rate based on prior year costs and utilization, and that the higher cost results directly from any one or more of several specific reasons. A common exception basis is the Aatypical service intensity (patient mix)@ criterion. This criterion comes into play when a facility maintains that the particular makeup of its patient population and resulting special demand for necessary and complex medical services generate higher than normal costs. Where this situation exists, the provider must prove the cause and how that translates into costs which are higher than the composite rate. The Intermediary points out that it is the facility which shoulders the burden of proof that it meets any of the criteria, and that its excess costs comply with reasonable cost principles. HCFA has no duty to prove that the facility fails to do so.

The Intermediary advises that very strict time frames govern the exception request submission, review and determination process. In order to have its exception request considered, the ESRD facility must file all requested materials so that the intermediary receives the information no later than 180 days after the facility received notice of it composite payment rate. These notices open Aexception windows,@ and the Intermediary has 15 days from the date the exception request is filed to determine whether the facility has supplied the requisite documentation to support its request. If the Intermediary concludes in a negative manner, and the 180-day period is not closed, the intermediary will return the exception request to the facility for necessary corrective action. While the ESRD facility may resubmit a corrected

exception request, it must do so within the remaining time in the 180-day period. The intermediary only makes a recommendation on the exception request, and HCFA makes the final decision.

The Intermediary points out that, in 1986, Congress added a statutory 60-working day time limit on HCFA=s disposition of exception requests after the 180-day filing period closes. In August of 1993, HCFA repealed its prior policy in HCFA Pub. 15-1 ' 2721.H, which arguably permitted providers additional time after the 180-day period to cure deficient exception requests. This change was implemented with HCFA=s issuance of Transmittal No. 23 to HCFA Pub. 15-1, which deleted '2721.H and modified other sections of Chapter 27, which specifically set forth HCFA=s policy for ESRD reimbursement and transplant services.[10] The Intermediary contends that Transmittal No. 23 actually formalized HCFA=s existing policy. Prior to August of 1993, decisions rendered by the HCFA Administrator clearly established that providers had no opportunity to perfect deficient or incomplete exception requests after the 180-day filing period expired. In support of this statement, the Intermediary cites the decision in St. James Mercy Hospital v. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield, PRRB Dec. No. 92-D65 September 22, 1992, Medicare and Medicaid Guide (CCH) & 40,859, rev=d. HCFA Administrator, November 17, 1992, Medicare and Medicaid Guide (CCH) & 41,045. HCFA formalized its existing policy in Transmittal No. 23 stating the following:

> Due to the short legislative time span of 60 working days in which to process an exception request and issue a final decision, all information related to the exception request must be submitted with the original submittal. The responsibility for furnishing an exception request with all required documentation rests with the facility. HCFA approves or denies the exception request based on the documentation submitted.

Transmittal No. 23 to HCFA Pub. 15-1 (emphasis added).

The statute at 42 U.S.C. '1395rr(b)(7) permits HCFA only 60 days to decide an exception request from the close of the 180-day filing period. Of those 60 days, the Intermediary has 15 days to review the request and make its recommendation to HCFA, leaving HCFA 45 days to issue a decision. Failure to meet this deadline produces an automatic Adeemed approval.@ Accordingly, the Intermediary argues that, if the ESRD facility files a defective exception request on the last day of the 180-day filing period, it assumes the risk that the defect may be material to the success of its request. Although the ESRD facility may appeal HCFA=s denial of its exception request to the Board pursuant to 42 C.F.R. ' 413.170(h)(2), the facility may not submit to the Board any Aadditional information or cost data@ that were not part of its submission to HCFA.

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[10] See Intermediary Exhibit I-4.

The Intermediary points out that the Provider=s exception request in the instant case was filed on April 29, 1994, which was the last possible day the request could be filed. The request sought relief on the basis of atypical service intensity at a rate of $146.80, an increase of $ 23.79 over the applicable composite rate of $123.01. HCFA denied the Provider=s exception request on July 18, 1994,[11] stating as its primary reason that the Provider=s calculation did not accurately include both home and maintenance dialysis programs. The Intermediary further notes that the narrative in the Provider=s exception request stated that there was no home program, even though the data in the supporting documentation showed otherwise.

At the hearing, the HCFA analyst who reviewed the exception request testified that the exclusion of the home program from the calculation was a sufficient basis to deny the exception request. Portions of his testimony are as follows.

> By Mr. Talbert
>
> Q. What is that, in the narrative, was the trigger or hot button for this conclusion? [to deny]
>
> A. Several things were involved. It wasn=t just one trigger.
>
> Q. We=re just talking about the narrative now.
>
> A. Yes, that=s all we=re going to look at. In the narrative, you=ve got the background, page one. Okay, background, page one. Page two at the bottom, we=re filing for atypical patient mix, and IEF. I know you said you don=t want to discuss IEF but too bad.
>
> Page three, I turn over and I see fourteen RNs, two LPNs, three techs, one social worker. This is a big operation; this is not a small operation.
>
> We expect to see 4,000 less treatments. I=ve already had trigger one. I=ve been told this is a major operation. Then you keep going along and you read, first off, then you say on page six, number 13, you say you=ve got a home program.
>
> Now you go back to an unmarked page, which would be page 14. They stopped numbering at page 12.

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[11] See Intermediary Exhibit I-3.

> You go a few more pages.
>
> At the bottom, they say: 100 percent of hospital=s ESRD patient population, or in-facility patient - none are home program patients.
>
> I read this. Uh-oh, we have an inconsistency right in the narrative itself. I continue going. I then go through the cost reports, numerous cost reports here, and I see they have a home program. They haven=t addressed home program. One place they said they had it; next place they said they don=t.
>
> This is confusing. I=m finished. And I was sustained by several levels of management.

Tr. at 177-178.

The Intermediary insists that the Provider=s omission of the home program undermined the credibility of the exception request, and would have required HCFA to reestablish the relief amount sought by the Provider before analyzing the substance of the request.

With respect to the Provider=s reliance on Provider Exhibits P-15 and P-15A, the Intermediary argues that recent corrections or modifications were made to these schedules which were not reflected on the original schedules included with the exception request. The Provider revised Exhibits P-15 and P-15A to cure the problem with the exception request filing. The Intermediary contends that the Board=s decisional framework is limited to the actual documentation and information which the Provider submitted as its exception request. The exception request was defective from the start and the relevant authorities properly authorized the denial.

However, recognizing that the Boards= authority is limited to reviewing what was submitted in the exception request, the Intermediary did review, through its HCFA witness, certain cost information submitted in the exception package. At the hearing,[12] the HCFA witness testified that a review of the budgeted cost information (after an incorrectly stated service unit count was modified) demonstrated that the Provider=s actual labor costs were less than the labor costs built into the composite rate. While the Provider=s supply costs and administrative costs exceeded the composite rate elements, the Provider never sought relief in those categories. Accordingly, atypical patients did not cause atypical labor costs because labor costs were not atypical. The conclusion was that, under the best set of circumstances, the Provider could not justify the relief sought in its exception request.

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[12] See Tr. at 194-195.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

' 1395 rr et seq.	-	Medicare Coverage for End Stage Renal Disease Patients

2. Regulations - 42 C.F.R.:

'' 405.1835-.1841	-	Board Jurisdiction
' 413.170 et seq.	-	Payments for Covered Outpatient Maintenance Dialysis Treatments
' 413.170 (f) et seq.	-	Procedures for Requesting Exceptions to Payment Rates
' 413.170(g) et seq.	-	Criteria for Approval of Exception Requests
' 413.170(h) et seq.	-	Appeals

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

' 2702	-	Composite Rate Payment - General
'2720 et seq.	-	General Instructions for Processing Exceptions Under Composite Rate Reimbursement System
' 2721 et seq.	-	Exception Requests - All Facilities

4. Case Law:

Mercy Hospital of Miami, Inc. v. Shalala, Case No. 91-3268, (D. D.C. Sept. 13, 1993).

St. James Mercy Hospital v. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield, PRRB Dec No. 92-D65, September 22, 1992, Medicare and Medicaid Guide (CCH) & 40,859, rev-d. HCFA Administrator, November 17, 1992, Medicare and Medicaid Guide (CCH) & 41,045.

University of California v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D18, January 25, 1995, Medicare and Medicaid Guide (CCH) & 43,051, rem=d. HCFA Administrator, March 26, 1995.

The Christ Hospital v. Blue Cross and Blue Shield Association/ AdminaStar Federal, Inc., PRRB Dec. No. 2000-D8, December 8, 1999, Medicare and Medicaid Guide (CCH) & 80,383, rem=d. HCFA Administrator, February 11, 2000, Medicare and Medicaid Guide (CCH) &80,416.

5. Other:

48 Fed. Reg. 21254 (May 11, 1983).

Transmittal No. 23 to HCFA Pub. 15-1, Chapter 27 - Reimbursement for ESRD and Transplant Services (August, 1993).

Program Memorandum to Medicare Intermediaries (HCFA Pub. 60A) - Reopening of the Exception Process Under the End Stage Renal Disease (AESRD@) Composite Rate System (October, 1993).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes that it was appropriate for HCFA to deny the Provider=s request for an exception to the ESRD composite payment rate based on atypical service intensity under 42 C.F.R. ' 413.170 (g)(1).

The record shows that, on April 29, 1994, the Provider timely filed its exception request with the Intermediary on the last day for filing an exception under the Awindow@ established by HCFA. On May 17, 1994, the Intermediary forwarded the Provider=s exception request package to HCFA with its recommendation that the requested rate of $146.47 be approved for atypical service intensity. Based on its review of the Provider=s exception request, HCFA informed the Intermediary on July 18, 1994 that the Provider=s request was denied because the Provider had not filed a fully documented exception request. Given the statutory time limit for the review process, and the inability of the Provider to cure its application after the Awindow@ closed on April 29, 1994, HCFA did not make a decision regarding the exception criteria, and issued its denial without an evaluation of the Provider=s cost or cost per treatment analysis.

The Board finds that the Provider=s exception request was not filed in accordance with the requirements set forth in 42 C.F.R ' 413.170(f) and (g) and Chapter 27 of HCFA Pub. 15-1. It is undisputed that

the Provider=s exception request did not account for its home dialysis program in calculating the exception amount sought under the composite rate. The provisions of HCFA Pub. 15-1 ' 2702, ' 2720 and ' 2721 clearly state that the composite rate is a comprehensive payment amount for all modes of in-facility and home dialysis treatments. In addition to the Provider=s failure to include the home dialysis program in determining an exception under the composite rate, the number of home program treatments included in the financial information submitted with the exception request were not converted to account for the home dialysis payment rate of 3/7th of the in-facility composite rate. Given the extent of the errors and inconsistencies in the Provider=s exception request, the Board finds that HCFA properly denied the Provider=s composite rate exception request based on its determination that the Provider did not file a fully documented exception request.

The Board notes that the Provider calculated three exception amounts in order to incorporate adjustments relating to the data for the home dialysis program. The original calculation included with the filed exception request sought a composite rate of $146.47 for hemodialysis ($123.01 plus $23.46), which excluded the CCPD and CAPD home patients.[13] Subsequent to the denial of its exception request by HCFA, the Provider modified its calculation of the exception amount to include the CCPD and CAPD modalities and determined a composite exception amount of $139.42 ($123.01 plus $16.41), which included treatments for home dialysis patients at a daily rate.[14] In order to convert the number of treatments for the home program patients to an equivalent basis with the normal composite rate (3/7th of the composite rate for in-facility outpatient dialysis), the Provider made a third calculation of the exception amount and calculated a composite exception amount of $143.29 ($123.01 plus $20.28), which is the exception amount that the Provider ultimately contends should be granted by the Board.[15] While the Provider contends that all of the data used for the three calculations were based on information embodied in the original exception request, neither Provider Exhibits P-15 nor P-15A was part of the original exception request submitted to HCFA for review and approval.

The Board finds that its is not reasonable to expect HCFA to analyze and interpret the home dialysis data that was buried in the Provider=s original exception request since this would have required considerable reformatting of the data and the application of numerous assumptions. Contrary to the Provider=s belief that it would have been a simple task on the part of the HCFA reviewer to revise the composite exception amount to incorporate the home dialysis program, the Board notes that the Provider=s interpretation of its exception request required extensive testimony at the hearing in order to clarify its position which was not part of its original submission. It is the Board=s conclusion that the burden of proof for justifying the exception request rested with the Provider, and that this responsibility was not fulfilled in its exception request for atypical service intensity.

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13 See Provider Exhibit P-4.

14 See Provider Exhibit P-15.

15 See Provider Exhibit P-15A.

DECISION AND ORDER:

HCFA appropriately denied the Provider=s ESRD composite rate exception request for atypical service intensity (patient mix) on the grounds that the Provider did not file a fully documented exception request. HCFA=s determination is upheld.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 20, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman