PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D5

PROVIDER –
Mercy Healthcare Bakersfield
Bakersfield, CA

Provider No.: 05-0295

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
United Government Services, LLC--CA

DATE OF HEARING -
May 6, 2003

Cost Reporting Period Ended -
June 30, 1994

CASE NO.: 94-3085

INDEX

ISSUE:

Was the Centers For Medicare and Medicaid Services (CMS)[1] partial denial of the Provider's End-Stage Renal Disease (ESRD) atypical service intensity exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pursuant to the provisions of §1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq., hospital-based and free-standing 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 generally 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 November 1, 1993, and ending on April 29, 1994. This appeal concerns various decisions by CMS on various cost elements within the exception request.

Mercy Healthcare Bakersfield (Provider) is a 278-bed acute care hospital located in Bakersfield, California. It provides outpatient dialysis services to the residents of Bakersfield and surrounding communities. The dialysis unit includes seven dialysis stations. The facility operates at near capacity treating fourteen chronic patients per day.[2] It primarily treats chronic renal patients who are extremely ill or require stabilization before returning to freestanding units. The unit also provides treatments to acute inpatients who are transported to the outpatient unit for treatment and to intensive care unit patients who are dialyzed in the ICU.[3]

In October 1993, the Provider was notified that its composite payment rate for outpatient ESRD services would remain at $134.55. However, the Provider was also advised that CMS was reopening the exception process, and that the Provider could request an exception to the rate by submitting an exception request on or before April 29, 1994.

The Provider submitted an exception request to the Intermediary on March 25, 1994.[4] The request sought an exception from the ESRD payment rate on the grounds that the Provider furnished ESRD services of atypical service intensity.[5] The exception request pointed to the following factors as demonstrating the atypical service intensity furnished by the Provider's ESRD unit and the increased costs the hospital incurred:

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[1] Previously known as the Health Care Financing Administration (HCFA)
[2] See Provider Exhibit A-1
[3] Id.
[4] See Provider Exhibit B.
[5] See Provider Exhibit A.

1. The Provider's ESRD unit treats an older patient population with 71% over age 55, compared with the national average of 64%;

2. 58% of the Provider's ESRD patients have a primary ESRD diagnosis of diabetic nephropathy, compared with a national average of 30%.

3. The Provider's standardized mortality ratio for 1992 was 3.11, ranking the facility with the highest mortality rate in its ESRD network. This mortality rate was 229% greater than the network rate of 0.82, and 211% greater than the national average of 1.00.

4. A vast majority of the Provider's ESRD patients are bedridden, including many who have lower limb amputations and other immobilizing conditions such as paralysis or joint disease. The Provider was the only local dialysis unit providing beds to accommodate the needs of these types of patients.

5. The entire patient population has prescription dialysis; therefore, the collection of supplies and the preparation of the concentrate both take longer.

6. Over 77% of the Provider's dialysis patients have cardiac complicating conditions, such as congestive heart failure, cardiomyopathy, and atrial fibrillation. These are among the most acute patients treated in the dialysis units.

7. None of the Provider's patients dialyzed at home. Patients who dialyze at home tend to have a lower acuity than patients who dialyze in facilities.

The Provider requested a revised ESRD payment rate due to the atypical nature of its services in the amount of $272.76.[6] This is the amount of the Provider's ESRD cost per outpatient dialysis treatment as determined on the Provider's Medicare cost report for fiscal year ended (FYE) June 30, 1993.[7]

The Intermediary performed a comprehensive review of the Provider's exception request and recommended that the Provider be granted an exception, and that its dialysis rate be set at $244.78.[8] CMS reviewed the Intermediary's determination and made additional adjustments to the Provider's exception request.

The following table summarizes the contested categories of the exception requested by the Provider, amounts recommended by the Intermediary, and the amounts finally approved by CMS:

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[6] See Provider's Post Hearing Brief at p. 12.
[7] See Provider Exhibit A.3.
[8] See Provider Exhibit P-1.

Category	Provider's Request	Intermediary's Recommendation	HCFA's Approved Amount	Difference Between Provider's Amount Request & HCFA's Approved
Salaries	$46.02	$46.02	$32.59	$13.43
Supplies	5.60	5.60	2.10	3.50
Lab	4.31	4.31	0	4.31
Benefits	21.87	21.87	6.09	15.78
Overhead Excluding Benefits	64.96	36.98	0	64.96
TOTAL	$142.76	$114.78	$40.78	$101.98

The Provider filed a timely request for hearing with the Provider Reimbursement Review Board (Board) seeking review of CMS' determination of the Provider's exception request. The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1805-405.1841. The Provider was represented by Lloyd Bookman, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSON:

The Board has reviewed each element of the cost disputed in the Provider's ESRD exception request, the Intermediary's recommendation on each disputed item, and CMS' final determination. After considering the Medicare law, regulations and program instructions, the Board finds and concludes as follows.

Regarding the salary cost of the lead nurse, the Board concurs with the Provider's argument that CMS' standard ESRD rate for salaries was unclear as to whether it included only direct labor or both direct labor and management of the nursing unit. CMS Pub. 15-1 §2723.D identifies all salaries in its median cost per treatment ($40) as a single amount. The Provider properly notes that this Provider Reimbursement Manual (PRM) section category does not differentiate between salaries that are for direct patient care or management of a department. The Intermediary's argument that the Provider did not clearly establish the lead nurse's activities in the department is unfounded. The Board finds that the fact that the Intermediary accepted the lead nurse's costs as included in the Provider's exception request is sufficient to accept these costs as claimed. The Intermediary conducted its review of the Provider on-site, while CMS only reviewed the Provider's exception request and the Intermediary's review. The CMS reviewer performed no analysis of the Provider's operations. As such, the Board concurs with the Intermediary determination of reasonableness of the lead nurse's salary and related activity and finds the CMS review unreasonable in light of the facts. Regarding the supplies and lab costs, both parties agree that no documentation was available to support the Provider's requested increase of $3.50 per treatment for supplies and the $4.31 per treatment for lab costs. Therefore, the Board denies both of those exception request elements.

Regarding the benefit costs, the Board finds that the Provider's use of its actual fringe benefit rate of 31.76% was reasonable, and that the Intermediary did not dispute the accuracy or reasonableness of this rate. The Board also concurs with the Provider's argument that CMS has no authority to limit a provider's fringe benefit rate to a national median rate, and that such limitation is inconsistent with 42 C.F.R. §413.9(c)(3). In addition, the Board concurs with the Provider's argument that this regulation allows costs, no matter how widely they vary, to be allowed unless they are found to be substantially out-of-line. In this case neither CMS nor the Intermediary determined the costs to be out-of-line.

Regarding the Provider's request for additional overhead (A&G) costs exclusive of fringe benefit costs, the Board finds that CMS' argument that there is no automatic recognition of additional administrative costs after direct costs are allowed under the exception request to be unreasonable and not in accordance with longstanding Medicare principles.

CMS refused to approve any increase for overhead costs exclusive of fringe benefit costs because it maintained that the Provider did not directly link those costs to the atypicality of the Provider's patients. However, it is not possible to directly link overhead costs such as administrative and general costs to a particular service, and there is no such incremental cost requirement in the Medicare regulations and Manual provisions. In addition, the Medicare cost reporting forms recognize that these costs need to be allocated to all patients.

CMS' rejection of this fundamental cost finding process in its exception request determination is inappropriate and inconsistent with its own development of its ESRD base rate. As can be seen at Board Appendix #1, CMS' national average of direct and indirect costs is $83.00, and the overhead cost exclusive of benefits is $47.00. This amounts to an average of $130.00 per treatment and an overhead rate of 56.65%. The separate elements of cost included in the national overhead rate have never been identified. The Board can only assume that the $47.00 represents general and administrative costs incurred by ESRD facilities and was calculated in accordance with long-standing Medicare principles and the cost-finding process. Based on this premise, the Board finds that when a provider incurs and CMS eventually approves incremental direct cost, appropriate general and administrative costs should be applied. In this case, CMS applied the national average benefit ratio of 17.5% to the Provider's allowed incremental labor costs to arrive at its allowed benefit cost per treatment. CMS would be inconsistent if it did not also allow an overhead factor for administrative and general costs.

The Board further finds that CMS' argument that overhead can only be recognized with a "cause and effect" showing is unreasonable in light of the above cost finding development process. A&G by definition is a residual cost, not specifically and reasonably identified with a particular area of a provider's operation. To require a provider to determine "incremental" A&G activity resulting from additional labor or

supplies would be excessively costly and extremely difficult to accomplish. Under CMS' theory, no provider could realistically receive any additional A&G costs. This is unreasonable in light of CMS' inclusion of $47 of general and administrative cost per treatment in its national average ESRD composite rate (36% of total costs included in that average). It is unreasonable to deny the Provider this additional overhead expense when it did incur incremental direct costs.

DECISION AND ORDER:

The Board allows additional labor costs and benefits costs claimed by the Provider and concurs with CMS' approved increase of $2.10 for Provider's supply costs. However, the Board denies the Provider's claim for additional $3.50 in supply costs and $4.31 in additional lab costs because no documentation was submitted to support those claims. The Board modifies Provider's claim for overhead costs exclusive of benefit costs and finds the Provider's composite payment rate treatment to be $221.75, allocated as follows: Salaries---$85.02; Lab costs---$3.00; Supply costs---$35.10; Fringe benefit costs---$27.32; Overhead exclusive of benefits costs---$70.31.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Dr. Gary B. Blodgett
Elain Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: November 19, 2004

Suzanne Cochran
Chairman

Board Appendix #1

	Provider's Request	Intermediary's Recommendation	CMS' Approved Amount	CMS' National Average
1. Salaries	$46.02	$46.02	$32.59	$40.00
2. Lab	4.31	4.31	0	3.00
3. Supplies	5.60	5.60	2.10	33.00
4. Benefits (Labor Related)	21.87	21.87	6.09	7.00
5. Total Direct & Indirect Cost Before A& G (sum of lines 1-4)	$77.80	$77.80	$40.78	$83.00
6. Overhead Other Than Benefits	$64.96	$36.98	0	$47.00
7. Ratio of Overhead Other Than Benfits To Total Costs (line 5 / line 6)	83.50%	47.53%	0	56.63%