PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D29

PROVIDER -
San Francisco Medical Center
San Francisco, CA

Provider No.: 05-0076

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
January 16, 2003

Cost Reporting Period Ended -
December 31, 1994

CASE NO.: 95-0468

INDEX

ISSUE:

Was the Intermediary's partial denial of the Provider's End Stage Renal Disease (ESRD) exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Congress established a prospective payment or composite rate for services furnished to Medicare end stage renal disease (ESRD) patients in 42 U.S.C. §1395rr(b)(7). The Secretary of Health and Human Services (Secretary) implemented the composite rate in regulations at 42 C.F.R. §413.170 et seq. The composite rate is a fixed amount that is paid for each outpatient treatment and was $139 per treatment during the period at issue in this appeal.

In recognition that certain outpatient dialysis facilities might be prejudiced by the composite rate limits, Congress authorized an exception process whereby a provider could request and be paid an amount higher than the composite rate, based upon certain unusual circumstances, to be determined by the Secretary. See 42 U.S.C. §1395rr(b)(7). The Secretary implemented the composite rate exception process in a regulation at 42 C.F.R. §413.170(g). It states in relevant part:

> HCFA[1] may approve exceptions to an ESRD facility's prospective payment rate if the facility demonstrates with convincing objective evidence that its total per treatment costs are allowable under Section 413.174, and that its per treatment costs in excess of its payment rate are directly attributable to any of the following criteria:
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> (1) Atypical service intensity (patient mix). A substantial portion of the facilities outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special needs of the facility's patients. The facility is able to demonstrate clearly that these services, procedures or supplies and its per treatment costs are prudent and reasonable when compared to facilities with a similar patient mix. Examples that may qualify under this criteria are more intense dialysis services that are medically necessary for patients such as:
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> (i) Patients who have been referred from other facilities on a temporary basis for more intense care during a period of medical instability, and who return to the original facility after stabilization;

[1] Health Care Financing Administration, subsequently renamed the Centers for Medicare and Medicaid Services (CMS). CMS is used hereafter in this decision.

* * * * *

(iii) Patients with medical conditions that are not commonly treated by ESRD facilities, and that complicate the dialysis.

42 C.F.R. §170(g).

The Secretary also issued guidelines interpreting the regulation in the Provider Reimbursement Manual (CMS Pub. 15-1), Chapter 27. The Provider has the burden of filing an exception request and demonstrating with convincing evidence that its total cost per treatment are allowable under 42 C.F.R. §413.174, and that its cost per treatment in excess of its payment rate are directly attributable to atypical service intensity (patient mix). 42 C.F.R. §413.170(f)(5) and CMS Pub. 15-1 §2721.

San Francisco Medical Center (Provider) is a Medicare-certified, acute care hospital located in San Francisco, California, which is owned and operated by the Kaiser Foundation Hospitals (KFH). The Provider operates a dialysis center for the treatment of patients with ESRD, and this center serves as KFH's regional dialysis center for its most ill and unstable patients in the San Francisco area. Exhibits P-2 at 4-6; Transcript from January 16, 2003 (Tr.) at 44-54; and Exhibit P-19 at 9.

Prior to the year at issue, the Provider submitted exception requests on March 24, 1987, November 13, 1987 and March 1988. CMS partially or fully denied all o f the 1987-1988 exception request, claiming that Kaiser did not furnish dialysis to an atypical patient population. Kaiser appealed those denials to the Provider Reimbursement Review Board (Board), which determined that Kaiser "exclusively served an atypical patient population," and that "since virtually every treatment was provided to an atypical patient, then essentially all costs incurred are directly attributable to such patients, thereby complying with the requirements of 42 C.F.R. §413.170(g)." The Board granted Kaiser nearly all of the costs requested in its 1987-88 exception requests. See Kaiser Foundation Hospitals – San Francisco Medical Center v. Aetna Life Insurance Company, PRRB Hearing Dec. 92-D6, January 23, 1992, Medicare & Medicaid Guide (CCH) ¶40,010, rev'd and remanded, CMS Administrator Decision, March 18, 1992, Medicare & Medicaid Guide (CCH) ¶40,788. The CMS Administrator reviewed the Board's decision and remanded it to the Board to grant the Intermediary and CMS an opportunity to render a determination as to whether the Provider's costs were reasonable, justified and attributable to its patient mix. Id. Pursuant to a settlement agreement, the parties agreed to a payment of $250 per dialysis treatment. Since the first exception request, the Provider has received approximately the same reimbursement for each dialysis treatment.

The Provider submitted its 1994 exception request at issue in this case on April 21, 1994 and requested $476.15 in total reimbursement per treatment due to patient mix, an exception of $337.15 over and above the composite rate of $139.00. Exhibits P-1 and P-2. CMS made a final determination of total reimbursement of $199.56 per dialysis treatment. Exhibit P-6. CMS granted an exception of only $46.33 for additional salaries,

$8.66 for additional employee benefits and $5.57 for supplies. Id. The Provider timely appealed CMS partial denial of its 1994 exception request to the Board.
The Provider was represented by Gina Reese, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Tom Bruce, CPA, of Mutual of Omaha Insurance Company.

PARTIES' CONTENTIONS:

The Provider argues that it has met all of the requirements of 42 C.F.R. §413.170(g)(1) and is entitled to the full amount of its exception request in the amount of $476.15 cost per treatment (CPT). Specifically, the Provider claims that it has demonstrated that: 1) it met all of the documentation requirements for its exception request; 2) CMS and the Intermediary have conceded that virtually all of its treatments are atypical and that it has incurred increased costs as a direct result of these atypical treatments; 3) CMS and the Intermediary have determined that its dialysis costs are reasonable and allowable; and 4) all of the increased costs incurred are directly attributable to its patient mix. The Provider also claims that it demonstrated that: 1) CMS and the Intermediary made serious errors in their analysis and computations of the Provider's requested costs; and 2) CMS' decision to grant the Provider significantly less for the 1994 Request than the $250 agreed upon by CMS as a result of the 1987-1988 requests was arbitrary, capricious and clearly erroneous. Based on this information, the Provider contends that the full amount of its exception request should be granted.

The Intermediary and CMS concede that the Provider presented convincing evidence that it rendered a substantial number of treatments to patients requiring more intense care during outpatient maintenance dialysis services and that it incurs higher than average per treatment costs for rendering these intense services. Exhibit P-6 at 1-2. However, the Intermediary contends that the Provider is only entitled to $199.56 per treatment, as previously noted.

The Intermediary contends that the Provider is only entitled to an exception of $46.33 for nursing salaries due to its patient mix, and notes that CMS used nursing hours worked to determine the average nursing hours per treatment and nursing hours paid to calculate the average hourly nursing rate for Provider's ESRD unit. The Intermediary notes that the Provider contends that this method mixes variables, hours worked versus hours paid. However, the Intermediary contends that this is the methodology used for all ESRD exception requests received and adjudicated by CMS.

The Intermediary contends that the Provider is entitled to an exception of $8.66 for related employee benefits, and notes that CMS calculated this amount by multiplying the additional CPT for salaries of $46.33 by the national average for employee benefits of 18.7 percent.

The Intermediary argues that the Provider is entitled to an exception of only $5.57 for supplies, and notes that, based on national data and general statistics, the CPT for supplies is $33. The Intermediary notes that Provider's Tab 26 to Exhibit P-2 contains a

summary CPT comparison for cost years (CY) 91 through 95 and that, from CY 92 to CY 93, the supply CPT increased $10.85 (28.1%) from $38.57 to $49.42. The Intermediary notes that, in accordance with CMS Pub. 15-1 §2721.F, an ESRD facility is required to provide an explanation of any significant increase or decrease in budgeted costs and data compared to actual cost and data reported on the latest filed cost report. The Intermediary argues that, since the Provider failed to address the significant increase in its supply CPT for CY 92 and 93, CMS is justified in limiting its approval of an additional CPT amount to the CY 92 supply CPT. Therefore, the Intermediary claims that the Provider is only entitled to an additional CPT amount of $5.57 ($38.57 less $33.00) for supplies.

The Intermediary contends that the Provider is not entitled to an exception for any overhead costs incurred; arguing that the Provider failed to link the additional items and/or services rendered with the Provider's corresponding incremental costs. See Exhibit P-3. The Intermediary notes that the Provider identified its actual and projected costs and discussed the adverse effects of its patient mix on these costs. However, the Intermediary claims that the Provider failed to identify or document the incremental costs associated with the additional items or services it rendered. The Intermediary notes that CMS Pub. 15-1 §2721.B requires a facility to provide written justification for the facility's high costs, and that the fact that a facility projects costs higher than its composite payment does not constitute adequate documentation for granting an exception. The Intermediary also argues that the facility must provide CMS with supporting material documenting the reasons that may justify its costs in excess of its composite payment rate and must separately identify those items and services that are in excess of the composite rate. The Intermediary contends that, in accordance with CMS Pub. 15-1 §2725.1.D, CMS is unable to recognize the higher overhead costs claimed by the Provider because the facility failed to submit documentation that identifies the specific additional items and/or services rendered that are in addition to a routine dialysis service and the incremental costs of these items or services.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

First, the Intermediary claims that the testimony presented by the Provider at the hearing or in the Provider's exhibits should be precluded from consideration by the Board under 42 C.F.R. §413.170(h)(3)(ii) (redesignated as 42 C.F.R. § 413.194(c)(3)). Tr. at 16-20. It provides that the facility may not submit to the reviewing entity any additional information or data that had not been submitted to CMS at the time it evaluated their request. The Provider responds that all of the additional information it presented at the hearing is simply a reiteration, clarification or explanation of the information and cost data submitted to CMS with the exception request, as well as information contained in the Intermediary's and CMS' determinations. The Provider presented a detailed breakdown of all information presented. See Provider Post-Hearing Brief at 69-73. The Board finds that the Provider did not present any new information or data that was not part of its initial request for exception and, therefore, the Board has considered all of the material in the record in reaching its decision.

Second, the Board finds that the Provider submitted an extremely detailed request for exception. In the request, the Board found evidence that the Provider was the referral center for complicated ESRD patients and that its patient population was entirely atypical. This fact was recognized by CMS in its determination letter.

With regard to costs in general, the Board agrees with the Provider's assertion that the regulations and manual provisions do not provide exact instructions as to what information and data are to be presented in order to substantiate that a cost is attributable to atypicality of patients, and that there are no breakdowns of the components of cost in the composite rate available to the Provider in developing its exception request. Despite the difficultly associated with presenting a request, the Board has examined the Provider's specific requests for additional costs to determine whether the type of cost claimed was attributable to atypical services, whether it was reasonable to incur those additional costs, the amount of additional cost claimed and the data presented to support the amount claimed. The detailed findings of the Board are presented below.

Labor Costs

With respect to the labor component, the Board agrees with the Provider that CMS incorrectly determined the nursing labor costs and that it should have permitted some of the other labor costs claimed by the Provider. The Board notes that due to the level of acuity of its patients, the Provider only uses Registered Nurses (RNs) in its unit. Tr. at 60. There is also clear evidence in the original exception request, Provider Exhibit P-2, Exhibit 21, that the Provider used 4.6 hours of nurses time per treatment. With respect to the nursing hour calculation, CMS used nursing hours paid to determine the average nursing hours rate (lines 10-15 on page 1 of Exhibit P-13) and then multiplied that rate times the nursing hours worked (lines 24-35 on page 1 of Exhibit P-13) to calculate the cost per treatment for nursing salaries (line 38 on page 1 of Exhibit P-13). Tr. at 203-209; Exhibit P-8 and P-13. "Nursing hours paid" includes amounts paid to the nursing staff for time worked as well as for vacation, holiday and sick time. Id. "Nursing hours worked" only includes amounts paid to the nursing staff for days actually worked. Using "nursing hours paid" in the first part of the calculation, and "nursing hours worked" in the second half of the calculation distorts the calculation by improperly disallowing the vacation, sick and holiday time Kaiser paid to its nursing staff. Id. This error can be corrected by using "nursing hours worked" in both parts of the calculation and results in an exception amount of $62.13 for nursing salaries, which is $15.80 per treatment more than the $46.33 granted by CMS. Id.

The Board also agrees with the Provider that CMS should not have used the "national average employee benefit percent," instead of Kaiser's actual employee benefit percent, to calculate the exception amount for employee benefits. Tr. at 210-215; Exhibits P-8 and P-13. There is no indication that the Provider's actual costs were unreasonable. To the contrary, the Intermediary did not disallow any costs as unreasonable. Using the Provider's actual employee benefit percent results in an exception amount of $15.28 per treatment that should be granted to the Provider for employee benefits, which is $6.62 per treatment more than the $8.66 granted by CMS. Id.

With regard to the Provider's claimed additional costs for other labor, including nursing supervision, unit assistants, and a physician medical director, the Board finds that the Provider submitted sufficient documentation to support some of its claims. The Board finds that the Provider's costs of a physician director is justified based on the acuity of the patients; however, the costs of the director's salary is limited by the Reasonable Compensation Equivalent (RCE). See Exhibit I-3 at Exhibit D. Evidence in the record clearly shows that the facility has a high turnover of patients which contributes to higher administrative costs. Exhibit P-2 at 17. The Board finds that the Provider's request for $4.95 per treatment for administrative cost is supported. The Provider also documented that 57% of its patients have severe nutritional deficiencies which justify additional direct labor and benefit costs of $1.55 per treatment for the services of a clinical dietician. Id. at 35.

The Board did not find convincing evidence that additional management costs could be attributed to patient atypicality.

Supply Costs

With respect to supply costs, the Board first notes that the Intermediary claimed that the Provider did not meet the requirements of CMS Pub. 15-1 §2721.F because it did not explain a significant increase in its cost of supplies. At the hearing, the Intermediary acknowledged that the wrong standard had been used and that no CMS Pub. 15-1 §2721.F violation exists in this case. The Board finds that the Provider presented specific rationale and data to support all of its increases in supply costs of $51.82. The detailed findings concerning each of the supply categories is presented below.

Subclavian Dressing Kits

The Board notes that 57% of the Provider's patient require the insertion of subclavian lines for vascular access during their dialysis facility. Exhibit P-3 at 6. Each time the subclavin line is accessed for dialysis, the nurses must use a subclavin dressing kit to clean and dress the insertion site and cap the catheter to ensure that the patient does not acquire a life-threatening infection through the line. Tr. at 85-86. The actual cost of the subclavian dressing kit is $2.34 per kit. Id. The Intermediary claimed in its determination that the incremental cost of the subclavian dressing kits was not justified because "[t]he $33.00 average cost per treatment for typical patient population includes $1.00 to $2.00 for supplies." Exhibit P-3 at 6; Tr. at 247-248. The Board disagrees and finds that the Provider's request for additional costs for subclavian dressing kits is justified.

Dialyzers

The Provider presented evidence that it is medically inappropriate and unsafe to sterilize and reuse hemodialyzers for its very ill and unstable patient population. Exhibit P-2 at 27; Tr. at 87-90. For example, it treats a higher number of patients with hepatitis and other infections than typical facilities, which precludes dialyzer reuse. Exhibit P-2 at 9.

The Intermediary contends that Provider's excess dialyzer cost treatment is not related to the special needs of the patients but rather is due to the fact that the Provider does not have the equipment to sanitize dialyzers. In addition, the Intermediary claims that the Provider's comparison of its dialyzer per treatment cost to that of facilities which reuse dialyzers ($25.20 versus $2.50) is flawed, because technician's salary, equipment depreciation and maintenance involved in sanitizing the dialyzers was not taken into account. Exhibit P-3 at 7. The Board disagrees and finds that the Provider's request for additional dialyzer costs is justified as being directly attributable to its atypical patient population.

Hypertonic saline

The Provider presented evidence that typical dialysis facilities rarely, if ever, use hypertonic saline, but its patients often require infusions of hypertonic saline to stabilize their blood pressure during dialysis, Tr. 94-96; Exhibit P-2 at 28, at an additional CPT of $0.94. Exhibit P-2 at 28 and Tab 30; Exhibit P-14. The Intermediary appears to agree that hypertonic saline is not used at typical dialysis facilities but only granted $0.40 CPT for this solution. The Board finds that the Provider's request for additional costs of $.94 for this supply is justified.

Gloves

The Provider delineated specific reasons why it needed additional gloves for treating its atypical patients and asserts it used 7 times more gloves than are used in a typical dialysis facility. Exhibit P-2 at 20-25 and 28 and Exhibit 14 and Tr. at 97-102 and 256-60. The Provider requested an exception for gloves of $1.60. The Intermediary's denial was based on the fact that some of Kaiser's staff had a latex allergy that necessitated use of non-latex gloves. Exhibit P-3 at 8. The Board finds that the Provider incurred a higher cost for gloves due to the volume of gloves used for its atypical patients and that its request for additional costs for this supply is justified.

Bicarbonate and Acid Dialysis Concentrate

The Provider asserts that it must use special Bicart on-line dialysis solution for its very unstable and ill dialysis patients to decrease the risks of bacterial contamination of the dialysate due to the very high risk of infection and unusual susceptibility to pyrogen reactions. Exhibit P-2 at 28-29; Tr. at 102-106. The Provider indicated that Bicart dialysis solution costs 2 to 3 times more per treatment than the manual method used in a typical dialysis facility, which it calculates is an increased cost of $4.69 CPT. Exhibit P-2 at 28-29; Tr. at 261-262. The Intermediary agreed that the Bicart on-line dialysate concentrate is necessary to decrease risk of infection in Kaiser's atypical patient population, but did not grant an exception due to this supply cost. Exhibit P-3 at 7; Tr. at 261. The Board finds that the Provider's request for additional costs for this supply is justified.

Wound Dressing and Cleaning Supplies

The Provider claimed that typical ESRD units do not perform wound dressing and cleaning services and do not use such supplies. Exhibit P-2 at 29; Tr. at 108. Therefore, an exception in the amount of $0.98 CPT for wound dressing and cleaning supplies is warranted. Exhibit P-2 at 29, Exhibit P-14; Tr. at 263-64. The Intermediary disputes that claim, asserting that such supplies are used in any dialysis unit and that the Provider used more expensive supplies for the special needs of its patients. Exhibit P-3 at 8. The Board finds the Provider's evidence credible. The Provider's request for $.98 additional costs per treatment for this supply is justified.

Overhead Costs

For Medicare cost reporting purposes, the cost of delivering services include both the direct costs incurred for labor and supplies and the indirect costs incurred by the facility or "overhead." Overhead costs in a hospital based setting include administrative and general costs (A & G), space and equipment, housekeeping, laundry and linen and employee benefits.[2] These overhead costs are allocated to all of the revenue centers they serve, usually using an allocation statistic such as accumulated costs, square footage or hours worked. The CMS ESRD composite rate provides $47.00 attributable to overhead and $3.00 for laboratory services.

The Provider points out that CMS has never provided any further detail as to what constitutes overhead and what proportion of the $47.00 is attributable to A & G, space and equipment, housekeeping, laundry and linen and employee benefits. Tr. at 280-282. Even though CMS has not provided any incremental cost information, it has refused to approve any increase in overhead because it maintains that the Provider has not directly linked the incremental costs to the atypically of its patients. The Provider asserts that it cannot perform any meaningful incremental analysis of these costs without CMS information and that it is reasonable to assert that increased direct costs due to its atypical patient mix in labor and supplies have caused an increase in indirect overhead costs such as A & G, etc. In addition, the Provider presented evidence that its atypical patient population necessitated increased A&G, space and equipment, employee benefits and laundry and linen costs. Exhibits P-2 and P-15.

The Board agrees with the Provider that it is not possible to link overhead costs directly to a particular service, that the Provider has presented evidence that its overhead costs are related to the atypical patients, and that there is no such incremental requirement in the Medicare regulations and Manual provisions. 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 direct labor or supplies would be excessively costly and extremely difficult to accomplish. Under CMS' theory, no provider could realistically receive any additional

[2] The employee benefit costs in this case are for personnel, education and training and organization development. They do not contain any of the direct costs for employee benefits which are accounted for in the dialysis cost center.

A&G costs. The Board has previously noted that when CMS developed its own ESRD base rate, CMS' proposed a national average of direct and indirect costs of $83.00 and an overhead cost exclusive of benefits of $47.00. See Mercy Healthcare Bakersfield v. Blue Cross Blue Shield Association/United Government Services, PRRB Case No. 2005-D5, November 19, 2004, Medicare & Medicaid Guide (CCH) ¶ 81,257, modified, CMS Administrator, January 19, 2005, Medicare & Medicaid Guide (CCH) ¶ 81,293. This amounts to an average of $130.00 per treatment and an overhead rate of 56.65%. The separate elements of the cost CMS 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 cost-finding process. Based on this premise, the Board finds that when a provider incurs and CMS eventually approves incremental direct and indirect costs, appropriate overhead costs should be applied. In this case, the Board finds that the 56.65% overhead factor should be allowed on all other costs approved in this decision.

DECISION AND ORDER:

The denial of the Provider's exception request is modified. The Provider's exception request is approved to the extent discussed above.

Board Members Participating:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: April 8, 2005

Suzanne Cochran, Esquire
Chairman