PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2005-D4

PROVIDER
Eastern Maine Medical Center
Bangor, ME

Provider No. 20-0033

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Associated Hospital Service

DATE OF HEARING
December 12, 2003

ESRD Window Closing
August 30, 2000

CASE NO. 01-1458

INDEX

ISSUE:

Was CMS' denial of the Provider's end stage renal disease (ESRD) composite rate exception request correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Eastern Maine Medical Center (Provider) is a voluntary not-for-profit hospital located in Bangor, Maine. The ESRD program at the hospital provides inpatient and outpatient dialysis services to 134 patients utilizing 15 dialysis stations. There are 12 dialysis stations at another site located in Ellsworth, Maine. This case concerns the Centers for Medicare and Medicaid Services' (CMS)[1] 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)[2] 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 HCFA 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" with an atypical service intensity and it provided self-dialysis training.

The Provider requested an exception rate of $198.84.[3] Upon review, the Intermediary recommended a rate of $178.91 to CMS.[4] CMS did not follow the Intermediary's recommendation, concluding that the Provider's request was incomplete and contained insufficient information to support its request. CMS denied the Provider's request for any rate increase.[5] As a result, the Provider continued to receive the standard hospital-based composite rate of $124.32 applicable to Penobscot County, Maine.

The Provider filed a timely request for a hearing with the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-1841. The Provider was represented by William H. Stiles, Esquire, of

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1 Previously called Health Care Financing Administration (HCFA).
2 42 U.S.C. §2395rr.
3 Exhibit P-6 .
4 Exhibit P-9.
5 Exhibit P-1.

Verrill and Dana, LLP. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross Blue Shield Association.

THE REGULATIONS:

The regulations establish that for a provider to be granted an exception to the payment rate, it must demonstrate that its costs in excess of the payment rate are "specifically attributable" or "directly attributable" to the criteria under which it seeks to qualify; in this case, "isolated and essential." 42 C.F.R. §413.180(f)(3) and §413.182. Section 413.180(f) addresses the documentation required generally for an exception request while Section 413.186 details the documentation needed to qualify under the isolated essential facility criteria. In addition, 42 C.F.R, §413.194(c)(2) states that:

> The facility may not submit to the . . . PRRB, any additional information or cost data that had not been submitted to [CMS] at the time [CMS] evaluated the exception request.

PARTIES' CONTENTIONS:

The Intermediary contends that the CMS determination was correct, as the Provider's application failed to meet the general documentation requirements at 42 C.F.R. §413.180 and the specific standards for exception requests at 42 C.F.R. §413.186.

The Provider contends that its request documented that the Provider's atypical patient mix in an isolated area resulted in higher computer costs, on-call costs, and greater overtime, as well as nursing and overhead inefficiencies related to the lower utilization of its third shift. In addition, the Provider contends that it serves a significantly higher diabetic population, and that it also provided home dialysis training on an accelerated schedule that caused the Provider to lose out on regular dialysis payment opportunities.

Furthermore, the Provider asserts that its request contained all the information as required by CMS Pub. 15-1 §2125, and that neither CMS nor the Intermediary requested additional information or clarification before the CMS denial.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and Program Instructions, evidence presented, and arguments of the parties finds and concludes that CMS properly denied the Provider's request for an exception to the end-stage renal dialysis composite rate.

The regulation at 42 C.F.R. §413.186 (c)(4) provides a list of items that must be submitted in a required format to support the Provider's request. These include a copy of the latest filed Medicare cost report and a list of patients by modality showing distance and time to the current and the next nearest renal dialysis facility.

The Board finds that the Provider failed to submit a completed cost report. Missing from the Provider's submission was Worksheet S-5, which is necessary to review statistical data specific to the ESRD department, such as the number of patients, treatments rendered, number of dialysis stations, etc. Nor did the Provider submit a comparison of the cost report at issue with the two preceding years. Thus, the Provider has not met the requirements of the regulation.

With regard to the issue of an "isolated essential facility," the Provider submitted the distance that its patients drive to the Provider's facility but did not furnish the distance to the nearest alternate dialysis facility as the regulations require. With regard to the "atypicality" of its patients, the Provider's documentation and numbers were inconsistent. Specifically, the exact number of patients could not be validated, nor could the length of stay be determined. Thus the cost information necessary to support a rate increase could not be determined.

The Board finds that the Provider also requested an exception based on the provision of home dialysis training. It provided home dialysis training through five consecutive longer sessions rather than fifteen shorter sessions following a dialysis treatment. The accelerated schedule was set up to accommodate patients who had to travel substantial distances. Because the Provider received payment for training only when it also provided dialysis, the Provider lost ten payment opportunities. However, because the Provider's submitted patient listing was deficient regarding the identification of modalities as well as the number of treatments, the amount exceeding the composite rate could not be determined.

Based on the above analyses, the Board concludes that CMS acted properly in denying the Provider's request based on the lack of required documentation. As such, the Board finds it is not necessary to address the Provider's arguments regarding actual costs in excess of the composite rate.

DECISION AND ORDER:

CMS properly denied the Provider's exception request.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: November 18, 2004

Suzanne Cochran
Chairman