PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE- RECORD
99-D44

PROVIDER -
Clearview Nursing Home
Juneau, Wisconsin

Provider No. 52-5394

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/United Government Services

DATE OF HEARING-
March 10, 1999

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 96-0529

INDEX

ISSUE:

Were the Intermediary's adjustments to ancillary cost centers proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Clearview Nursing Home ("Provider") is a skilled nursing facility located in Juneau, Wisconsin. During 1993, the Provider had contractual and billing arrangements with an independent contractor for the provision of physical therapy, occupational therapy, speech pathology, medical supplies, and pharmacy services to its patients. The Provider billed the Medicare program for these inpatient therapy services rendered to Medicare Part A patients. It paid the contractor for those services and included the costs in its physical therapy, occupational therapy, and speech pathology cost centers. The contractor billed and collected for all other patients receiving the above services at the Provider. These patients included Medicaid, Medicare Part B and private pay patients. The Provider's records did not include the costs and billing data for the latter patients.

United Government Services ("Intermediary") disallowed any overhead cost allocation to the above cost centers on the 1993 cost report because the Provider did not: (1) accurately apply the "gross-up" method in apportioning indirect costs for these ancillary services or (2) make a timely "gross-up" election. The "gross-up" method is accomplished by imputing the direct costs for physical therapy, occupational therapy, and speech pathology for non-Medicare patients and including the total costs of therapy services for these patients in the appropriate cost centers. The Provider's charges for the non-Medicare patients would also be "grossed-up" to include charges made by the independent contractor. If these two "gross-ups" were done, an overhead allocation would be applied to the direct costs through step-down cost reporting with the resulting overhead cost being apportioned to Medicare based on the ratio of Medicare charges to total charges. Since this was not done, the Intermediary used the "no overhead allocation" method in Provider Reimbursement Manual, HCFA Pub.15-1 ("HCFA Pub. 15-1") § 2314.A, resulting in a reduction of approximately $10,000 in Medicare reimbursement.

The Provider contested the Intermediary's adjustment by filing an appeal to the Provider Reimbursement Review Board ("Board"). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Joseph M. Lubarsky, CPA, of BPO Seidman, LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the issue presented in this appeal has previously been resolved by the Board in favor of the Provider's position. See, Florida Life Care, Inc. Group - "Gross Up"

v. Aetna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide (CCH) § 38,522 "Florida Life Care". There are no material differences between this case and the Provider's case. There have been no intervening developments that would warrant a different result here. Additionally, the Board addressed the enforcement of the 90-day rule and the issue of cross-subsidization in Sunbelt Health Care Centers Group Appeal - v. Aetna Life Insurance Co., PRRB Dec. No. 97-D 13, December 3, 1996, CCH § 44,923 ("Sunbelt Health Care"). See, also, Pinnacle Care Drug "Gross-Up" Group Appeal v. Aetna Life Insurance Co., PRRB Dec. No. 97-D41, March 26, 1997, CCH § 45,167 ("Pinnacle Care").

The Provider concludes that the Intermediary's argument that the Provider should have requested the use of the "grossing up" method based on the fact that the Intermediary made the same adjustments to the 1992 cost report is not valid. The 1992 cost report was finalized by the Intermediary on March 31, 1994, the same date that the 1993 cost report was filed. This certainly did not allow sufficient time for the Provider to make a timely election based on the settled 1992 cost report. In any event, the Intermediary has allowed the use of the "grossing up" method in the following year when it was denied in the prior year. The Intermediary has in other situations considered the denial of the use of the "grossing up" method and disallowance of overhead as an informal request to use the method. To be consistent with this practice, if an audit adjustment in the prior year is considered notification that prior approval was needed to use the "grossing up" method, it should also be considered an informal approval to use the grossing up method in the subsequent year. Regardless of whether the Provider should have requested the use of the grossing up method, the Board found in similar cases that this method is the more accurate method of allocating costs. Accordingly, the Board should hold that the Intermediary's adjustments were in error, and that the Intermediary must accept the Provider's ability to use the "grossing up" method for 1993.

The Provider argues that the Board's rulings are directly on point. In Florida Life Care, Sunbelt Health Care, and Pinnacle Care, the facilities had contractual and billing arrangements with outside suppliers for the provision of various services such as physical therapy, occupational therapy, speech pathology, and pharmacy services. Like the Provider, the facilities' agreements with the suppliers made the facilities responsible for billing for Medicare Part A patients. The suppliers would handle billings not only for Medicare Part B patients but also for Medicaid and private pay patients. As here, the facilities maintained, disclosed, and made available documentation for use in the "gross-up" method to allocate overhead costs to these cost centers. In Florida Life Care, the intermediary adjusted the cost reports to use the "no overhead allocation" methodology because the facilities had not made a timely request, nor did they allocate overhead costs to non-Medicare therapy payers in the therapy cost centers for the filed cost report according to the "gross-up" methodology under HCFA Pub. 15-1 § 2314.B. In Sunbelt Health Care, and Pinnacle Care, the intermediaries adjusted the cost reports to use the "no overhead allocation" methodology because the facilities had not made a timely request to use the "gross-up" methodology under PRM § 2314.B.

The Provider notes that the above providers made a series of arguments that they should be permitted to use the "grossing-up" methodology despite the absence of the "gross-up" methodology and the absence of prior intermediary approval. These arguments included:

- The Manual's prior approval requirement is inconsistent with the Secretary's statutory obligation to make retroactive corrective adjustments under 42 U.S.C. § 1395x(v)(1)(A). These adjustments can only be made after submission of the cost report when the relevant facts (and not assumptions) are known and final. Therefore, the prior approval requirement cannot be harmonized with the duty to make appropriate adjustments retroactively.

- The Manual provision violates the prohibition on cross-subsidization under 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.5(a) because it results in less accurate Medicare reimbursement and non-Medicare patients bearing costs that are undeniably attributable to Medicare patients.

- Manual provisions are not binding when they are not consistent with the controlling statutory or regulatory provisions.

- The "grossing-up" method is more accurate than the "no overhead allocation" method and should have primacy. The facilities also presented evidence on this point.

- The prior approval requirement serves no legitimate purpose because no financial or other cost report information must be submitted to the intermediary to approve or disapprove the use of the "grossing-up" method. Moreover, adequate information is available to the intermediary upon audit where it can review the "grossed-up" data to determine whether the use of the "grossing-up" method is appropriate under the circumstances.

- The prior approval rule was not being enforced by the intermediaries in any event, and there were instances in which they had allowed use of the "grossing-up" method without prior approval.

- The Manual provision exacts an unduly harsh penalty for the failure to obtain prior approval. See, Columbia Iron and Metal Co. v. Commissioner, 61 T.C. 5 (1973). The tax court held that disallowance of an income tax deduction due to the taxpayer's failure to submit documentation with the tax return was too harsh.

The Board concurred with these arguments.

The Provider notes that although 42 C.F.R. §§ 413.20 and 413.24 deal generally with providers' financial data and reports and with adequate cost data and cost finding, HCFA Pub 15-1 § 2314 specifies the various methods of allocating indirect costs when ancillary services

such as physical, occupational, and speech therapy are furnished to the providers' patients by others under arrangement.

INTERMEDIARY CONTENTIONS:

The Intermediary contends that the “gross-up” method is not allowable because proper approval was not received as required under PRM 15-1 § 2314- Limitation of Allocation of Indirect Costs Where Ancillary Services Are Furnished Under Arrangements. It states:

> In order to use the "grossing-up" technique, the provider must receive the intermediary's approval within-90 days after the beginning of the cost reporting in which the "grossing- up" technique will be used.

Id. (Emphasis added).

The Provider never received approval to use the grossing up method, therefore, the Intermediary properly disallowed any overhead allocation to these departments because they are 100% Medicare departments.

The Intermediary notes that the Provider is arguing that the Provider Reimbursement Manual is in conflict with the Medicare regulations in this case. However, the Foreword to the Provider Reimbursement Manual[1], states the following:

> This manual provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended.

Id. (Emphasis added.)

This section goes on to say:

> The procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard as to where covered services are furnished.

Id. (Emphasis added.)

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[1] See Provider Exhibit 1.

Finally, this section more specifically addresses the issue at hand with the following:

> A change of method must be approved by the intermediary (or SSA for providers dealing directly with the government) on a prospective and not retrospective basis. Where the manual sets a time limit for requesting such a change, or limits the number of changes, the provider and intermediary will be guided by the manual instructions.

Id. (Emphasis added.)

This section makes it very clear that the purpose of the HCFA Pub. 15-1 is to ensure proper implementation of the Medicare regulations. Therefore, by following these instructions, the regulations are being properly followed. The Intermediary was correct in disallowing overhead allocations to the therapy departments since the Provider never received proper approval to use the "grossing up" method.

The Intermediary observes that in the Provider's position paper it is stated that the parties agree
that the Provider maintained, disclosed, and made available documentation to support the use of the "gross-up" method. This is not a valid point since the Provider submitted the cost report without the appropriate "gross-ups" and failed to request proper approval even after it was made aware of the necessity to do so. The Intermediary is not required to review data that was not submitted on the cost report when it was clearly the Provider's responsibility to include this data on the cost report and obtain proper approval for this submission. The instructions in the Provide Reimbursement Manual were written to be followed by both the Provider and the Intermediary. Failure to follow these, even after having been made aware of the situation by prior year adjustments, is not acceptable.

CITATION OF PROGRAM LAW, REGULATIONS AND INSTRUCTIONS:

1. Law-42 U.S.C:

§ 1395x(v) (1)(A)	-	Reasonable Cost.

2. Regulations 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5(a)	-	Cost Reimbursement: General
§ 413.20	-	Financial Data and Reports

§ 413.24 - Adequate Cost Data and Cost Finding

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

§ 2314, et seq. - Limitation of Allocation of Indirect Costs Where Ancillary Services Are Furnished Under Arrangement.

4. Case Law:

Florida Life Care, Inc. Group - "Gross Up" v. Aetna Life Insurance Company, PRRB Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,522, declined review HCFA Administrator, June 14, 1990.

Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996, Unpublished, declined review HCFA Administrator, January 14, 1997.

Pinnacle Care Drug "Gross-Up" Group Appeal v. Aetna Life Insurance Co., PRRB Dec. No. 97-D41, March 26, 1997.

Columbia Iron and Metal Co. v. Commissioner, 61 T.C. 5 (1973).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions , and evidence presented, finds and concludes that the Intermediary's adjustments disallowing the Provider's use of the "gross-up" method were improper.

The Board finds that there are two methods available to providers for allocating indirect costs where ancillary services are furnished under arrangement. Specifically, the "no overhead allocation" method and the "grossing-up" method described at HCFA Pub. 15-1 § 2314.A and B, respectively. The Board also notes the manual's requirement that providers obtain prior approval to use the "grossing-up" method. In part, HCFA Pub. 15-1 § 2314.B states:

> [i]n order to use the "grossing-up" technique, the provider must receive the intermediary's written approval within 90 days after

> the beginning of the cost reporting period in which the "grossing-up" technique will be used.

Id.

The Board finds that the Provider's use of the gross-up method even without prior approval is consistent with 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.5(a). Clearly, the "grossing-up" method results in a more accurate determination of Medicare reimbursement and helps prevent non-Medicare patients from bearing the cost of services that are undeniably attributable to Medicare patients. The Board finds that the Intermediary's adjustments disallowing the Provider's use of the grossing-up method result in a less accurate method of cost finding.

In Florida Life Care the provider argued that it should be permitted to use the "grossing-up" method despite the absence or prior intermediary approval. In that case the Board agreed, stating:

> [c]learly, the "gross-up" method results in a more accurate cost finding approach. As such, it is consistent with the Medicare law and regulations. The Board does give great weight to, but is not bound by, the PRM. In this case, it finds the 90-day PRM limit for granting permission to use the "gross-up" technique is unreasonable because missing the 90-day deadline results in less accurate cost finding. This results in an improper underpayment of the Provider's costs and conflicts with 42 U.S.C. § 1395x(v) and 42 C.F.R.
> § 405.402.

Florida, (CCH) ¶ 38, 522 at 22,946.

The Board also finds that a letter written by HCFA, dated March 31, 1995, which is referenced in Sunbelt Health Care reinforces its decision to allow the provider's to use the gross-up method even though they had not obtained prior approval from the Intermediary. In part, that letter states:

> [t]he provider ignored a threshold requirement. . .by failing to obtain approval from the fiscal intermediary to use the direct assignment of costs. While we believe that this is an important requirement that should not be ignored by providers, our enforcement of this requirement has been reshaped by practical considerations. We have never been sustained on appeal in situations where failure to obtain prior approval is the only defect in a provider's use of a cost allocation alternative. The

> PRRB has adopted a "no harm, no foul" approach to enforcing this requirement. That is, as long as the provider's cost allocation alternative produces a more appropriate and more accurate allocation of cost, and is supported by adequate, auditable documentation, the provider's alternative has been accepted.

Id.

Based on this analysis, the Board finds that the Provider should have been allowed to use the "gross-up" method in 1993.

DECISION AND ORDER:

The Provider can "gross-up" its charges and costs even though it did not receive prior Intermediary authorization because this method is more accurate than the method required by the Intermediary. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: May 04, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman