PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

99-D54

PROVIDER - Health Visions Home Care

Provider No. 55-7160

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Wellmark Blue Cross and Blue Shield of Iowa

DATE OF HEARING-
September 9, 1998

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 97-3024

INDEX

ISSUE:

Was the Intermediary's adjustment reclassifying non-allowable costs of community liaison employees to a non-reimbursable cost center proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Home Visions Home Care, Inc. ("Provider") is a home health agency ("HHA") located in San Leandro, California. On its fiscal year ended ("FYE") December 31, 1995 cost report, the Provider claimed costs associated with two community liaison employees. Wellmark Blue Cross and Blue Shield of Iowa ("Intermediary") disallowed all of the costs for these two employees. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $55,000.

The Provider claimed costs for two employee who were engaged in community liaison activities. Based upon a review of the job description for these employees,[1] the Intermediary determined that some of the responsibilities and duties included non-reimbursable activities. The Intermediary determined that the Provider did not have sufficient time records to support an allocation of the employees' time between allowable and non-allowable functions. The Intermediary established a non-reimbursable cost center to disallow all salary costs related to these two employees.

The Provider was represented by John W. Jansak, Esquire, of Harriman, Jansak and Wylie. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider asserts that prior to 1995, the cost reporting year in question here, the previous intermediary always reimbursed the Provider for the costs of the employees engaged in community relations based on the same documentation that the HHA maintained for the 1995 cost reporting year. The Intermediary made no effort to explain to the HHA the type of documentation it required to document the community liaison position, made no effort to obtain that documentation from the Provider, and failed to question Provider staff concerning the activities of the two employees. Instead, relying solely on a generic job description maintained by the Provider, prepared before these employees were hired, the Intermediary denied the Provider's claim for their salaries.

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[1] See Intermediary Exhibit 1.

The Provider contends that all of the time spent by these employees was in reimbursable activities. Since the Provider's inception, certain Provider employees were included in community liaison and worked under a generic community liaison job description.[2] In conducting its audit, the Intermediary did not speak to any of the Provider's employees, managers or other providers that referred patients to the HHA, and based its adjustment solely on that generic description. The Intermediary did not contact the previous intermediary to determine how it handled similar claims in the past.

The Provider states that the job description was prepared in 1992, and was generic to all community liaisons. The Provider notes that the health background of one of the community liaison persons was in durable medical equipment and that he also had experience with requests for proposals and liaison with health care providers. The Provider also notes that the other employee's background was in the practice of medicine and the employee had expertise in setting up and explaining to the medical community and staff, programs for the care and treatment of psychiatric and AIDS patients. The Provider asserts that the job description described allowable activities and that the Intermediary's determination that there were non-allowable activities was incorrect and not supported by factual evidence. The Provider further notes that despite having left employment with the Provider and having nothing to gain, one employee maintained that his activities were reimbursable.[3]

The Provider indicates that the Intermediary reviewed the 15 job description duties and responsibilities and marked five of them as non-reimbursable. However, the evidence and testimony at the hearing did not support their conclusions. The reasons given for believing these activities are not allowable are that the job description "describes activities that are related to discharge planning, promoting the agency and increasing utilization, all of which are ... unrelated to patient care." [4] The Intermediary also stated the manning of exhibition booths at professional conferences was also not allowable.[5]

First, the Provider points out that testimony showed these were professional conferences and not conferences attended by potential patients.[6] Second, the Provider indicates that statements from referral sources, with first hand information concerning the employee's activities, rebut

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[2] See Provider Exhibit 4.

[3] See Tr. at 34.

[4] See Intermediary Exhibit 2.

[5] See Provider Exhibit 3.

[6] Tr. at 25.

the auditor's conclusions that non-allowable activities were taking place.[7]

The Provider observes that the Intermediary's reimbursement supervisor testified that there were other ways to document the activities of the employees on the job, other than logs or time sheets,[8] that the Intermediary did not interview the Provider's staff, patients or other providers concerning their activities and thus, relied only on the job descriptions.[9]

The Provider contends that independent third-party evidence,[10] has been submitted which clearly shows that the activities questioned by the Intermediary are allowable under HCFA Pub. 15-1 §§ 2113.1 (coordination activities), 2113.4 (education and liaison activities), and 2136.1 (public relations activities, such as manning exhibition booths). That evidence is also supported by the testimony of the Intermediary's own witness who testified that the activities engaged in by these employees were reimbursable.

The Provider contends that there was documentation available to support the allowability of the costs under 42 C.F.R. § 413.20. The Intermediary argues that time logs (secondary documents) are needed. For example, a particularly egregious error by the auditors was to disallow costs at educational conferences. "We also noted costs claimed in the Education account for exhibition booths at various conferences which were manned by these two employees. We have removed this cost on W/P 3-3c."[11] Contemporaneous documentation that this conference was for community professionals was presented,[12] and thus, it should be an allowable cost for both employees.

The Provider also submitted primary evidence from the referral sources showing solicitation activities were not engaged in by any Provider employee. These documents relate to the activities of the two liaisons at the point in time they were working for the Provider and, thus, are contiguous to the cost year in question.[13]

The Provider asserts that the evidence presented shows that the activities of one employee was primarily in-house to help coordinate and set up programs, educate the referral source

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7 See Provider Exhibits 2 and 11 through 19, Tr. at 35-40.

8 Tr. at 183.

9 Tr. at 195-197.

10 Tr. at 135.

11 Intermediary Exhibit 1, at 3-6.

12 Tr. at 5.

13 See Provider Exhibits 12 through 20.

staff and respond to physician telephone contacts. There was no evidence to show that he performed any non-allowable activities outside the office. With regard to the other employee, there was a contemporaneous contract between Kaiser Foundation Hospitals and the Provider,[14] that described the employee's allowable activities during the period in question.

In summary, the Provider contends that the compensation paid to two community liaison employees was for allowable activity. The Provider contends that the allegations made by the Intermediary that the job descriptions described non-allowable activities was incorrect. Moreover, because the activities were 100 percent allowable under the Medicare program, there was no need to have the time records to split the activities between allowable and non-allowable activities. Under 42 C.F.R. § 413.20, a provider must have documentation to support the allowability of its activities. In general, the Provider provided statements of three hospitals and seven doctors from which they receive patient referrals stating that their rules prohibit solicitation. Moreover, a contemporaneous contract with Kaiser Foundation Hospitals showed the activities of one employee who was specifically identified as the Provider's coordinator. The Provider asserts that the evidence submitted was not rebutted in any way by the Intermediary. The Provider also documented that the other employee worked mostly in-office and, thus, there was no need for time records to split his out-of-office activities. Moreover, during the audit the Intermediary made no findings to show that any of the activities were non-allowable. Since there is contemporaneous evidence showing only allowable activities and no evidence showing any unallowable activities, the adjustment should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA Pub. 15-1 § 2113 distinguishes between allowable home health coordination and non-allowable patient solicitation activity. Home health coordination, or intake coordination, intended to manage and facilitate the transfer of patients from a hospital or skilled nursing facility to the care of a home health agency is an allowable cost under the program. However, costs which constitute patient solicitation activities are not allowable. Visits to patients who have not yet been referred to the home health agency or visits to physicians for purposes of solicitation of business would not be allowable. HCFA Pub. 15-1 § 2113.2. Similarly, discharge planning activities performed by home health agency personnel would not be allowable. HCFA Pub. 15-1 § 2113.3.

The Intermediary states that they reviewed the job description of the community liaison at the Provider and determined that job description included activities that could amount to non-allowable patient solicitation. The Intermediary indicated that the job description left questions as to whether certain activities were to take place before or after a patient was referred to the agency. For example, the responsibilities of the community liaison included an item described as: evaluate patients for Medicare eligibility by patient chart review. The same

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[14] See Provider Exhibit 23.

item in the job description referred to "potential patients."[15] The Intermediary witness indicated the description does not indicate when the chart review is to take place.[16] Chart review of patients cannot take place before referral to the agency. Further, the reference to "potential patients" raises questions as to whether the community liaison was reviewing charts of potential patients to determine if referral was a possibility. The job description also lists as a job responsibility, "confers with nurses, social worker, and therapists involved with the patients in hospital care."[17] The Intermediary again questioned whether the activity would take place before referral to the agency.[18] An additional job responsibility refers to participating in discharge planning activities.[19] The Intermediary questioned if this was directed at discharge planning at the hospital or skilled nursing facility, which would not be allowable.[20] Finally, the job description refers to educational activity" including working in conjunction with a referral source to provide community oriented programs and understanding of home care."[21] The Intermediary contended that presentations to the general public would not be an allowable cost under the Medicare program.

The Intermediary argued that some of the job responsibilities described in the community liaison job description may or may not be allowable activities under HCFA Pub. 15-1 § 2113 depending on whether they took place before or after the referral of the patient to the agency.[22] Some of the training and education activity might be allowable educational activities, or might amount to non-allowable advertising cost under HCFA Pub. 15-1 § 2136.2.[23]

The Intermediary witness testified that in cases where the job description is not clear as to the nature of activities performed by the community liaison, additional documentation is requested to substantiate the allowable activity. The Provider is expected to maintain sufficient financial records and statistical data to support the costs claimed on the cost report.

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15 See Intermediary Exhibit 1.

16 Tr. at 164.

17 See Intermediary Exhibit 1.

18 Tr. at 165.

19 See Intermediary Exhibit 1.

20 Tr. at 165.

21 See Intermediary Exhibit 1.

22 Tr. at 168.

23 Tr. at 169-170.

42 C.F.R. § 413. 20. Further, the instructions at HCFA Pub. 15-1 § 2113 indicate that the Provider should maintain supporting records such as time logs to substantiate their statements pertaining to the time spent by HHA personnel in the various activities. In this case, the provider did not maintain any time records to support the allocation of 100 percent of the community liaisons' time to allowable activities.

The Intermediary pointed out that other documents indicated the community liaisons were performing duties that would not be considered allowable activities under the program instructions. Minutes of the Provider's Advisory Committee of February 22, 1995, indicated the community liaison personnel were introduced as a part of a marketing plan review, and included a review of the increase in referrals and revenues for the preceding three months.[24] In addition, minutes of an office staff meeting of June 21, 1995 indicated the community liaison had obtained a new referral source.[25] Finally, minutes of the agency's Advisory Committee dated July 25, 1995, discusses, under the heading of "marketing" "we now have one community liaison .... to help Linda." The reference goes on to describe a new contract for referrals and a relationship with a hospital for "discharge planning."[26] In her testimony, the Provider's Director indicated one community liaison person worked on responses to requests for proposals issued by insurance carriers or health maintenance organizations with which the agency wanted to do business.[27] This activity could also amount to marketing activity in that it is directed at increasing referral sources.
The Intermediary argues that the language in the job descriptions and the other documents referencing the community liaison positions connected to marketing activity, raised significant questions as to whether the activities of the community liaisons amounted to non-allowable activities under the Medicare program instructions.

Because the Provider could not document the time spent, the Intermediary had no basis for an allocation between allowable and non-allowable activities. The job description did not provide a reliable basis for an allocation, because there was evidence that some responsibilities in the job description were never undertaken by the job incumbents, while other activities actually
performed by the incumbents, were not listed in the job description.[28] The Intermediary also refers to Board and HCFA Administrator decisions that hold that absent sufficient supporting documentation to distinguish between allowable and non-allowable costs the intermediary

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[24] Intermediary Exhibit 1-3.

[25] Tr. at 174.

[26] Tr. at 175.

[27] Tr. at 42.

[28] Tr. at 53 and 178.

properly disallowed costs in full and correctly created a non-reimbursable cost center. See Harriet Holmes Health Care Services v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Case No. 97-D43, April 7, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,169, HCFA Administrator declined review, May15, 1997 and In Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, Iowa, Illinois and Wisconsin, HCFA Administrator, August 4, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,594.

The Intermediary contended that the program instructions clearly state that home health coordination activity must relate to allowable services to be reimbursable. The Provider is required to understand and abide by applicable regulation and program instructions. In this case the Provider employed a consultant to advise them on reimbursement matters.[29]

In summary, the Intermediary contends that the community liaison positions included responsibilities which may be non-allowable patient solicitation, or duplicate discharge planning. In addition, some of the education and training activity may be general advertising to the public and therefore non-allowable cost under HCFA Pub. 15-1 § 2136. Moreover, testimony at the hearing indicated the community liaisons were performing duties that were not described in the job description, such as marketing duties, and that the community liaisons may not have performed every duty that is described in the job description. The Provider did not maintain sufficient records to support the claim for reimbursement of the community liaison cost. Since the community liaison personnel were using office space, telephone and other general overhead services, it is appropriate to establish a non-allowable cost center and allocate overhead cost to the community liaison function.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding

[29] Tr. at 63.

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

§ 2113 et seq.	-	Home Health Coordination Costs - General
§ 2136 et seq.	-	Advertising Costs - General
§ 2136.2	-	Unallowable Advertising Costs

4. Cases:

Harriet Holmes Health Care Services v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Case No. 97-D43, April 7, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,169, HCFA Administrator declined review, May15, 1997

In Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, Iowa, Illinois and Wisconsin, HCFA Administrator, August 4, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,594.

In Home Health v. Blue Cross and Blue Shield Association/Various, PRRB Case No. 97-D71, June 20, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,557, HCFA Administrator declined review, September 16, 1997.

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 brief, finds and concludes as follows:

The Board recognizes the Intermediary's concern that the community liaison employees may have been engaged in unallowable activities such as discharge planning, patient solicitation and marketing. The Board finds that the job description that the Intermediary was concerned about is rather vague and some activities could be construed as non-allowable. The Board also notes the reference to the community liaison employees under the heading of marketing in its meeting minutes is also questionable. And finally, the Board finds that the exact nature of the activities of the employees at the professional conference could make those activities either allowable or non-allowable.

The Board observes that the Provider has the burden of presenting auditable evidence that its employees were engaged in allowable activities. 42 C.F.R. §§ 413.20 and 413.24. The Board notes that HCFA Pub. 15-1 § 2113 states that "HHAs must be able to produce supporting records such as time logs to substantiate their statements pertaining to the time spent" in

home health coordination activities. In addition, the Board notes that it has previously indicated the types of data that should be maintained to document these activities. See In Home Health v. Blue Cross and Blue Shield Association/Various, PRRB Case No. 97-D71, June 20, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,557, HCFA Administrator declined review, September 16, 1997. In the instant case, the Board finds that the Provider did not present clear auditable evidence that the two employees in question were only engaged in allowable activities.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the costs of the Provider's community liaison employees was correct. The Intermediary's adjustment is affirmed.

Board Members Participating:

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

Date of Decision: June 30, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman