# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

2000-D82

**PROVIDER** -
Cameo Care Center, Inc.
Milwaukee, Wisconsin

Provider No. 52-5504

**vs.**

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

**DATE OF HEARING-**
February 29, 2000

Cost Reporting Period Ended -
June 30, 1994

**CASE NO.** 96-2052

**INDEX**

ISSUE:

Was the Intermediary=s recalculation of the Provider=s gross-up method proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cameo Care Center, Inc. (AProvider@) is a Medicare certified skilled nursing facility located in Milwaukee, Wisconsin.[1] During its fiscal year ended June 30, 1994, the Provider furnished physical therapy, occupational therapy, and speech therapy services to its patients through an arrangement with an outside contractor. Under the arrangement, the Provider billed for therapy services rendered to Medicare beneficiaries while the contractor billed for therapy services furnished to all other patients.

As a result of the Provider=s billing arrangement with its therapy contractor, the Provider=s accounting records reflected only those therapy costs and charges applicable to Medicare patients. Therefore, the Provider used the Agrossing-up@ method of cost finding to prepare its Medicare cost report pursuant to program regulations at 42 C.F.R. ' 413.24, and program instruction contained in the Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1@) ' 2314.B.[2]

United Government Services (AIntermediary@) reviewed the Provider=s cost report and determined that the Provider had not received prior approval to use the grossing-up methodology as required by the program=s rules. Therefore, it disallowed the Provider=s use of the grossing-up method and no overhead expenses were allocated to the therapy cost centers.[3] On February 26, 1996, the Intermediary issued a Notice of Program Reimbursement (ANPR@) reflecting its disallowance. On April 24, 1996, the Provider appealed the Intermediary=s adjustment to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835.-1841, and met the jurisdictional requirements of those regulations.[4]

Thereafter, on December 16, 1997, the Intermediary was advised by the Health Care Financing Administration (AHCFA@) that it could waive the prior approval requirement if all other requirements of HCFA Pub. 15-1 ' 2314 were met. Upon this advice, the Intermediary waived its disallowance but also performed a review of the Provider=s actual grossing-up computations. As a result of this review, the Intermediary proposed to resolve the Provider=s appeal by allowing it to use the grossing-up

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1 Provider Position Paper at 2.

2 Intermediary Position Paper at 3.

3 Id.

4 Intermediary Position Paper at 1.

method. However, the Intermediary=s proposal also required a modification to the charge statistic used by the Provider to gross-up therapy maintenance service. In effect, the Intermediary=s proposal would reimburse the Provider approximately $15,000 for overhead allocated to its therapy departments as opposed to the approximate $80,000 amount in controversy based on the Intermediary=s total disallowance of the grossing-up method. The Provider did not accept the Intermediary=s proposal.[5]

The Provider was represented by Robert M. Hesslink, Jr., Esq., of Hesslink Law Offices, S.C. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.[6]

PROVIDER=S CONTENTIONS:

The Provider contends that the only substantive issue in this case is whether or not the Intermediary properly denied use of the grossing-up method because the Provider failed to obtain prior approval. Respectively, the Provider asserts that the Intermediary's denial is clearly improper.[7]

The Board has consistently held that a provider's failure to timely provide a Agross-up letter@ is not a valid basis for an intermediary to deny that provider the opportunity to use the grossing-up method of cost reporting.[8] Florida Life Care, Inc. Group - AGross-Up@ v. Aetna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990, Medicare and Medicaid Guide (CCH) & 38,522, decld rev., HCFA Administrator, June 12, 1990,[9] and Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D13, Dec. 3, 1996, Medicare and Medicaid Guide (CCH) &44,923, decl=d rev., HCFA Administrator, January 14, 1997 (ASunbelt Health Care Centers@).[10] Notably, in the more recent case, Sunbelt Health Care Centers, the Board specifically found that Athe Provider's use of the >grossing-up= method, even without prior approval, as described in HCFA Pub. 15-1 ' 2314.B, results in a more accurate cost finding approach.@ Id.

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5 Intermediary Position Paper at 3. See also Exhibit I-10 at D.

6 The Board acknowledges an error in the Transcript (ATr.@) to this case. At page 93 line 9, Provider Counsel=s cross-examination is stopped. Further questions resumed on line 11 are mistakenly attributed to Intermediary=s Counsel.

7 Provider=s Post Hearing Brief at 5. Tr. at 31.

8 Provider=s Post Hearing Brief at 7.

9 Exhibit P-9.

10 Exhibit P-10.

The Intermediary, itself, now acknowledges that the basis of its original disallowance is not valid. On page 5 of its position paper the Intermediary states: A[i]n conclusion, the Intermediary will waive the approval requirement and allow the gross-up method of settlement. . . .@ Id.

In fact, the Intermediary was aware, or should have been aware that HCFA was no longer enforcing the prior approval requirement prior to its disallowance. See March 1995 letter from Director, Office of Hospital Policy, HCFA, to Associate Counsel, Blue Cross and Blue Shield Association.[11] Therefore, the Intermediary's denial should be reversed, and the Intermediary ordered to repay its original disallowance of $77,662, plus $7,340.38, which is the interest incurred by the Provider over a twelve month period repaying the overpayment caused by the Intermediary=s disallowance of the gross-up method.[12]

In summary, the Provider contends that the sole basis for the Intermediary=s denial of its use of the grossing-up methodology was the fact that it did not obtain prior approval. And, given that that requirement is no longer a valid basis for such a denial, this case should end here. Notwithstanding, the Provider contends that even if the Board looks beyond this point, the Intermediary should not be allowed to change its position and modify the Provider's original grossing-up computation.[13]

Specifically, the Intermediary did not respond to discovery requests even after being ordered to do so by the Board, failed to submit a preliminary position paper as required by the Board=s scheduling order, and failed to timely submit its witness and exhibit lists. These failures warrant a default order entered in favor of the Provider.[14] Clearly, when a party does not comply with a discovery request the usual remedy is to obtain an order of compliance. However, once such an order has been issued, courts consistently hold that an inexcusable failure to comply with such an order renders a default judgment appropriate. AAlthough entry of a default judgment is an extreme measure, discovery orders are meant to be followed.@ Bambu Sales v. Ozak Trading 58 F.3d 849, 853 (2d Cir. 1995) (ABambu Sales@). See also National Hockey League v. Metropolitan Hockey Club, 427 U.S. 639 (1976), reh=g den=d., sub. nom., United States v. Janis, 429 U.S. 874 (1976); Hilao v. Estate of Marcos, 103 F.3d 762 (9th Cir. 1996) (A[t]he fact that Appellants have made no attempt to explain or excuse their failure . . . suggests that the failure was deliberate@); and, Pope v. Lexington Ins. Co., 149 F.R.D. 586, 588 (E.D. Wis. 1993) (Abecause of his total failure even to attempt to respond to the discovery requests made of him, I find that the sanction of dismissal is warranted@).

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[11] Exhibit P-17.

[12] Exhibit P-E at 6.

[13] Provider=s Post Hearing Brief at 6.

[14] Provider=s Post Hearing Brief at 8.

Continuing, the Provider explains that it issued a set of interrogatories and other document requests to obtain an explanation for the Intermediary=s continued resistance to its use of the grossing-up method. In part, those discovery requests inquired as to: Aeach and every basis for disallowance of the gross-up method for physical, occupational and speech therapy services@ and requested that the Intermediary: A[p]roduce copies of any and all letters, memoranda, statements or other documentation which were used to make your determination.@ Provider Interrogatories[15] Importantly, the Provider asserts that when the Intermediary received the interrogatories and requests for production of documents, it already knew that HCFA had given instructions not to continue to deny use of the grossing-up method based on a lack of prior approval.[16] The Intermediary chose, however, to neither respond to the Provider=s discovery requests nor to refund the recoupment. Instead, the Intermediary chose to withhold the evidence favorable to the Provider.

Notably, before discovery began, the Intermediary issued an internal memorandum to its staff which stated that disallowances of the grossing-up method, based on the prior approval requirement, were being consistently rejected by the Board, and that such prior approval was no longer necessary. And, while not directly applicable to the instant case, Rule 11 of the Federal Rules of Civil Procedure provides sanctions for anyone responsible for continuing to maintain a legal position in federal court after learning that it has no merit. Denny v. Hinton, 131 F.R.D. 659 (M.D. N.C. 1990); Blossom v. Blackhawk Datsun, Inc., 120 F.R.D. 91 (S.D. Ind. 1988); Farino v. Advest, Inc., 111 F.R.D. 345 (E.D. N.Y. 1986); and Woodfork v. Gavin, 105 F.R.D. 100 (N.D. Miss. 1985).

The Provider contends that the Intermediary should also not be allowed to change its position and modify the Provider=s original grossing-up computation because the modification was not fairly disclosed in the Joint Statement of Issues filed with the Board.[17] The Provider argues that the Intermediary=s failure to disclose its new position by responding to discovery requests that pointedly inquired into it, even after having been ordered to do so by the Board, effectively deprived the Provider of an opportunity to obtain facts necessary for a proper rebuttal. Clearly, the Intermediary=s failures rendered the Provider incapable, for example, of obtaining any information to refute Intermediary testimony that its auditors had no knowledge of HCFA=s 1995 memorandum waiving the prior approval requirement. Therefore, the Provider=s hearing preparation seriously suffered and the Provider was put at a substantial disadvantage at the hearing.

The Provider asserts, therefore, that if the Intermediary is permitted to pursue its new-found theories under these circumstances, not only is the Provider prejudiced in its ability to respond to those theories, but the Intermediary would be permitted to actually benefit from its failure to comply with the Board's

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[15] Exhibit P-12. See also Provider=s Post Hearing Brief at 2.

[16] Provider=s Post Hearing Brief at 9.

[17] Provider=s Post Hearing Brief at 12.

orders. And, as the court of appeals noted with approval, the magistrate in Bambu Sales v. Ozak Trading, supra, found it improper for Arecalcitrant parties to benefit from their tactical obstruction.@ Bambu Sales, 58 F.3d at 853.

The Provider contends that the Intermediary should also not be permitted to change the basis of its disallowance based upon program instructions regarding cost report reopenings.[18] According to HCFA Pub. 15-1 ' 2931.1.A, an intermediary has three years after the conclusion of a provider cost report audit to reopen such cost report to correct additional errors. With respect to the instant case, the audit of the subject cost report was concluded on February 26, 1996. The only adjustment made to the grossing-up method of cost finding raised during that audit was the Provider=s failure to obtain prior approval. At no time during more than four intervening years did the Intermediary take any action to reopen the cost report to assert the Acalculation errors@ that it is now asking the Board to adopt. Therefore, since the time for reopening the subject cost report has passed, the Intermediary is now asking the Board to do something indirectly that it is foreclosed from doing, i.e., reopening the subject cost report after more than four years and make adjustments for alleged errors that were neither found nor raised in the original audit.

Notwithstanding each of these arguments, the Provider contends there is no legal basis for the adjustment the Intermediary seeks to make to its grossing-up statistic.[19] Specifically, the Intermediary argues that the Provider=s grossing-up methodology is unreasonable because the charge statistic applied to therapy maintenance units was less than the cost of the units. Therefore, the Intermediary wants to modify the calculation by increasing the maintenance units charge to an amount it believes is proper. However, as shown in Exhibit P-4, the Provider=s actual charge for therapy maintenance was $10.00 per unit and its cost was $18.90 per unit.[20]

Essentially, the therapy contractor billed all levels of therapy services it provided at the same rate. The Provider's charge structure, however, differentiated between the levels of such services. In part, the Provider charged more for restorative therapy, which requires the services of a licensed therapist, and less for maintenance units, which had no such requirement. Notably, the Provider used its own standard charge structure to apportion overhead costs to the non-Medicare patient services as required by HCFA Pub. 15-1 ' 2314.B.

The Provider argues that the Intermediary=s position is also contrary to prior Board holdings. The Provider cites Fenton Park Nursing Home v. Blue Cross and Blue Shield Association/Empire Blue Cross, PRRB Dec. No. 94-D6, December 30, 1993, Medicare and Medicaid Guide (CCH) & 42,05l,

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[18] Provider=s Post Hearing Brief at 12.

[19] Provider=s Post Hearing Brief at 15.

[20] Provider=s Post Hearing Brief at 1. Tr. at 23 and 34.

decl=d rev., HCFA Administrator, February 9, 1994 (AFenton Park@), where the issue was the method of grossing-up covered therapy costs and non-covered maintenance units as in the instant case. The Provider notes that in Fenton Park the Board recognized that the cost of providing maintenance units was less than the cost of providing restorative therapy units: A[t]he maintenance treatment can be rendered by an aide at lower cost. . .@ Id. at & 38,984. The Provider asserts that the difference between Fenton Park and the instant case is that the Provider charges a lower amount for maintenance units while the facility in Fenton Park provided maintenance units for free. In both cases, however, the Intermediary sought to impute a higher charge for the maintenance therapy units for grossing-up purposes.

The Provider adds that the Medicare program does not dictate the charge structure a health care facility must use. HCFA Pub. 15-1 ' 2203. With respect to the instant case, the Provider's charge structure included lower rates for the less-skilled maintenance therapy units. And, since the Medicare program already embraces the principle of Alower of cost or charges,@ HCFA Pub. 15-1 ' 2600 et seq., the concept of charging less for a service than its cost is not startling.

Finally, the Provider explains that HCFA Pub. 15-1 ' 2314.B specifically provides for the use of a provider's Astandard charge structure@ for grossing-up services to non-Medicare patients. Using the charge structure of a servicing entity for grossing-up purposes is only permissible where the provider does not have a charge structure. Id. And, since the Intermediary failed to show that it is inequitable for the Provider to charge less for the less valuable maintenance units, the Provider=s standard charge should be used to compute the grossing-up method at issue.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment modifying the Provider's grossing-up computation is proper. The rules for using the grossing-up method of cost finding are found at HCFA Pub. 15-1 ' 2314.B.[21] In part, these instructions state:

> AGrossing-Up@ Method **C** If the intermediary determines that a provider is able to Agross-up@ the costs and charges for services to non-Medicare patients so that both charges and costs are recorded as if the provider had provided such services directly, then indirect costs may be applied to the ancillary department.
>
> AGrossing-up@ of costs means applying to the non-Medicare patient services the same schedule of charges used by the servicing entity to bill the provider for Medicare patient services. Cost so determined should be added to the costs of services of Medicare patients. AGrossing-up@ of charges means applying the provider's standard charge structure to the non-Medicare patient

[21] Intermediary=s Post Hearing Brief at 4.

> services. If the provider does not have a charge structure, the charge structure used by the servicing entity may be used to apportion costs if it provides for similar charges for similar services to both Medicare and non-Medicare patients. Charges so determined should be added to charges for services to Medicare patients and used to apportion costs in accordance with the apportionment method the provider is required to use under the program.

HCFA Pub. 15-1 ' 2314.B.

Accordingly, the Intermediary asserts that in order for a provider to use the grossing-up method, it must accurately develop two figures. First, it must identify equivalent costs for its non-Medicare patients. And next, it must develop a charge statistic for its non-Medicare patients so that the cost report will reflect charges for all patients. And, since the underlying premise is that grossing-up results in an accurate method of cost finding, a provider=s imputed costs and charges must be examined consistently with 42 C.F.R. ' 413.53, which states:

> (a) Principle. Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries.
>
> Charges means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

42 C.F.R. ' 413.53(a) and (b).

Respectively, the Intermediary contends that the Provider violated the basic definition of charges as used as an apportionment tool.[22]

Specifically, the Intermediary explains that the grossing-up method submitted by the Provider presented costs and charges for several types of speech, occupational and physical therapy services furnished by its contractor, and billed to the various different payors. The Intermediary accepted these statistics in each category of service except physical therapy services identified as general maintenance therapy. For that service, which made up 65.9 percent of total physical therapy service units, the Provider used an $18.90 cost per unit to gross-up costs. That was the same unit cost as Medicare Part A physical therapy services which made up 24.2 percent of total service units. However, the Provider charged $30.00 for the Medicare service but included only a $10.00 charge for the therapy maintenance service.

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[22] Intermediary=s Post Hearing Brief at 6.

The Intermediary contends that this grossing-up methodology distorts the apportionment of costs to the Medicare program. The distortion is illustrated in Exhibit I-10 at section C, and covered in testimony. Essentially, Medicare charges equal 42.7 percent of total charges. Therefore, Medicare should pay approximately 42.7 percent of all overhead costs. Under the Provider's grossing-up methodology, however, the Provider is claiming Medicare reimbursable physical therapy costs of $155,594. This amount is $17,697 greater than the total direct Medicare physical therapy cost of $75,467 plus the total overhead allocation to physical therapy of $62,430.[23]

Notably, grossing-up the cost for a non-Medicare service at the same $18.90 cost as the primary Medicare service implicitly asserts that the Medicare service was priced at a 50 percent profit and the non-Medicare service was priced at a 50 percent loss. In effect, accepting the accuracy of the Provider=s gross-up for therapy maintenance service requires accepting the premise that its contractor charged $10.00 a unit for 10,588 maintenance units that cost $18.90 or a loss of $8.90 per unit.

The Intermediary's remedy accepts the tendered grossing-up cost of $18.90 per unit. That is the same cost the therapy vendor actually charged the Provider for the Medicare covered physical therapy service. Then, the Intermediary reasons that if the costs were the same the charge should also be the same. Therefore, it asserts that the charge used to grossed-up the maintenance service should be $30.00 to maintain the parity required by 42 C.F.R. ' 413.53.

The Intermediary contends that an alternate remedy would be to use the $10.00 maintenance charge tendered by the Provider to recalculate the equivalent cost using a mark-up/mark-down consistent with the Medicare services ($18.90/$30.00). The result would have been a significantly lower cost but a similar bottom line outcome.[24]

The Intermediary rejects the Provider=s arguments that Aprior approval@ is the only substantive issue in this case, i.e., because the Intermediary did not issue a revised NPR effectuating its modified grossing-up calculation after it was determined that lack of prior approval would not be raised as an absolute defense.[25] The record demonstrates that the prior approval requirement could be waived if all other requirements of HCFA Pub. 15-1 ' 2314 were met, i.e., if accuracy was established. Exhibits I-2 and P-17. In this regard, and as argued earlier, the Provider's grossing-up methodology contained a material inaccuracy. Therefore, instead of rejecting the grossing-up on its merits, the Intermediary tried to correct the errors. Under this set of circumstances there is no authority dictating that the Intermediary must make payment. The Intermediary acted within its discretion by letting the adjustment advance to the Board, and argue for the modification.

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[23] Tr. at 71-75.

[24] Tr. at 78.

[25] Intermediary=s Post Hearing Brief at 9.

The Intermediary also rejects the Provider=s argument that it be granted full relief based upon procedural problems.[26] In general, the Provider argues that the Intermediary=s initial adjustment denying use of the grossing-up methodology should be reversed because the Intermediary failed to file a preliminary position paper, did not respond to discovery requests even after being ordered to do so by the Board, and failed to file a position paper by the prescribed due date. In response, the Intermediary acknowledges the difficulties these issues may have caused the Provider. However, the Intermediary also asserts that an objective look at the record does reflect a severe case of miscommunication.[27]

The Board issued its Discovery Order on September 17, 1998. At that time efforts to settle the dispute were in place. Exhibit I-5. The Intermediary=s position paper was filed on January 22, 1999. The position paper=s conclusion was:

> [i]n conclusion, the Intermediary will waive the approval requirement and allow the gross-up method of settlement after all errors have been corrected. The Provider as of yet has not indicated whether the Intermediary=s submitted audit adjustments would be accepted as a final administrative resolution.

Intermediary Position Paper at Conclusion.

The Provider=s position paper was filed seven days later. The arguments were over prior approval, additional statistical arguments should be barred, default for not responding to discovery and late preliminary position papers. There was a footnote discussion of the merits. The paper advanced no argument as to why the provider disagreed with the Intermediary=s modification to the grossing-up statistic. In effect, the Provider made a tactical decision to seek a complete reversal based on its procedural arguments rather than initiate an effort to resolve the confusion. So in all, neither side was completely innocent.

Also, the Intermediary rejects the Provider=s reliance upon the decision rendered in Fenton Park.[28] The Intermediary asserts that the Fenton Park case did not involve any issue of how to develop cost and charge statistics for purposes of identifying and allocating overhead under the circumstances described in HCFA Pub. 15-1 ' 2314. Rather, in Fenton Park the provider had no charges for its maintenance services for any payor. Therefore, its intermediary developed (grossed-up) charge statistics for non-Medicare patients but none for Medicare covered patients. The result was to apportion no maintenance costs to Medicare notwithstanding the acceptance of the premise that Medicare covered maintenance services were furnished. The Board did not like this outcome, and its solution was to eliminate the gross-up statistic and apportion maintenance costs based upon the relative Medicare volume of restorative treatments to total treatments.

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[26] Intermediary=s Post Hearing Brief at 10.

[27] Tr. at 80.

[28] Intermediary=s Supplemental Post Hearing Brief at 2.

Finally, the Intermediary rejects the Provider=s assertion that it (the Intermediary) is attempting to dictate the Provider=s charges. Initially, the Intermediary explains that the Provider was neither incurring a cost nor charging a payor or patient for therapy maintenance services during the subject fiscal year.[29] The Intermediary adds that there is also a line of Board decisions recognizing that actual charges may be modified for purposes of cost apportionment. In St Mary=s Hospital and Medical Center v. Blue Cross of California/Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D45, April 24, 1998, Medicare and Medicaid Guide (CCH) & 46,271, decl=d rev., HCFA Administrator, June 17, 1998, the appealing hospital was successful in convincing the Board that it was appropriate to have one charge for business purposes but substitute (gross-up) a different charge for cost apportionment. In St Mary=s Hospital v. Blue Cross and Blue Shield United of Wisconsin/Blue Cross and Blue Shield Association, PRRB Dec. No. 83-D42, March 15, 1983, Medicare and Medicaid Guide (CCH) & 32,482, decl=d rev., HCFA Administrator, April 8, 1983, rev=d and rem=d., U.S. District Court (W.D. Wis. 1983) No. 83-C-445-S, rev=d. U.S. Court of Appeals (7 th. Cir. 1985) No. 84-1443, the intermediary prevailed in the effort to modify (gross-up) actual charges to produce an accurate apportionment.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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| '' 405.1835.-1841 | - | Board Jurisdiction |
| ' 405.1869 | - | Scope of Board's Decision Making Authority |
| ' 413.24 et seq. | - | Adequate Cost Data and Cost Finding-Principle and Definitions |
| ' 413.53 et seq. | - | Determination of Cost of Services to Beneficiaries |

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

| | | |
|---|---|---|
| ' 2203 | - | Provider Charge Structure as Basis For Apportionment |
| ' 2314 et seq. | - | Limitation of Allocation of Indirect Costs Where Ancillary Services are Furnished Under Arrangements |

[29] Tr. at 36-41 and 77.

' 2600 - Lower of Cost or Charges

' 2931.1.A - Reopening and Correction

3. Case Law:

Florida Life Care, Inc. Group - AGross-Up@ v. Aetna Life Insurance Co., PRRB Dec. No. 90-D25, May 9, 1990, Medicare and Medicaid Guide (CCH) & 38,522, decl=d rev., HCFA Administrator, June 12, 1990.

Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D13, Dec. 3, 1996, Medicare and Medicaid Guide (CCH) &44,923, decl=d rev., HCFA Administrator, January 14, 1997.

Fenton Park Nursing Home v. Blue Cross and Blue Shield Association/Empire Blue Cross, PRRB Dec. No. 94-D6, December 30, 1993, Medicare and Medicaid Guide (CCH) & 42,05l, decl=d rev., HCFA Administrator, February 9, 1994.

St Mary=s Hospital and Medical Center v. Blue Cross of California/Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D45, April 24, 1998, Medicare and Medicaid Guide (CCH) & 46,271, decl=d rev., HCFA Administrator, June 17, 1998.

St Mary=s Hospital v. Blue Cross and Blue Shield United of Wisconsin/Blue Cross and Blue Shield Association, PRRB Dec. No. 83-D42, March 15, 1983, Medicare and Medicaid Guide (CCH) & 32,482, decl=d rev., HCFA Administrator, April 8, 1983, rev=d and rem=d., U.S. District Court (W.D. Wis. 1983) No. 83-C-445-S, rev=d. U.S. Court of Appeals (7 th. Cir. 1985) No. 84-1443.

Bambu Sales v. Ozak Trading 58 F.3d 849 (2d Cir. 1995).

National Hockey League v. Metropolitan Hockey Club, 427 U.S. 639 (1976).

United States v. Janis, 429 U.S. 874 (1976).

Hilao v. Estate of Marcos, 103 F.3d 762 (9th Cir. 1996).

Pope v. Lexington Ins. Co., 149 F.R.D. 586 (E.D. Wis. 1993).

Denny v. Hinton, 131 F.R.D. 659 (M.D. N.C. 1990).

Blossom v. Blackhawk Datsun, Inc., 120 F.R.D. 91 (S.D. Ind. 1988).

Farino v. Advest, Inc., 111 F.R.D. 345 (E.D. N.Y. 1986).

Woodfork v. Gavin, 105 F.R.D. 100 (N.D. Miss. 1985).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, testimony elicited at the hearing, and post-hearing briefs, finds and concludes as follows:

The Provider used the grossing-up method of cost finding to determine program payments for its physical therapy, occupational therapy, and speech therapy costs centers. The Intermediary made an adjustment to the Provider=s cost report disallowing use of the grossing-up method because the Provider had not obtained prior approval to use that methodology as required by program instructions. Subsequently, however, the Intermediary waived the prior approval requirement and proposed a modification to the Provider=s grossing-up calculations. Specifically, the Intermediary proposed to accept all of the Provide=s grossing-up statistics except for the charge statistic used to gross-up physical therapy/maintenance. The Intermediary argues that the charge applied to that service should be increased from $10.00 per unit to $30.00 per unit to coincide with the charge applied to other physical therapy services furnished Medicare beneficiaries.

Significantly, the Provider argues that the issue in this case should be restricted to the actual cost report adjustment made by the Intermediary, i.e., disallowing the Provider=s use of the grossing-up method of cost finding based upon the prior approval requirement. The Provider finds support for this argument in the fact that the Intermediary never issued a revised NPR effectuating its proposed revision, and other procedural matters.

With respect to this particular argument, the Board finds that the issue in this case is not restricted to a simple reading of the actual cost report adjustment made, i.e., the prior approval requirement. Rather, the Board is compelled to consider all facts established by the parties and to rule based upon the merits of all arguments presented. The Board refers to the regulatory description of its authority at 42 C.F.R. ' 405.1869, which states:

> [t]he Board shall have the power to affirm, modify, or reverse a determination of an intermediary with respect to a cost report and to make any other modifications on matters covered by such cost report (including modifications adverse to the provider or other parties) even though such matters were not considered in the intermediary=s determination.

42 C.F.R. ' 405.1869.

Proceeding, the Board finds that HCFA Pub. 15-1 ' 2314.B. provides the rules for using the grossing-up methodology. Essentially, these rules explain that a provider may gross-up its costs and charges in order to allocate overhead expenses to its ancillary cost centers if it can identify the charges used by its servicing entity to bill for Medicare patient services, and has its own charge structure which can be applied to non-Medicare patient services. In pertinent part, the manual states:

> [i]f the intermediary determines that a provider is able to Agross up@ the costs and charges for services to non-Medicare patients so that both charges and costs are recorded as if the provider had provided such services directly, then indirect costs may be applied to the ancillary department.
>
> AGrossing-up@ of costs means applying to the non-Medicare patient services the same schedule of charges used by the servicing entity to bill the provider for Medicare patient services. Cost so determined should be added to the costs of services of Medicare patients. AGrossing-up@ of charges means applying the provider's standard charge structure to the non-Medicare patient services. If the provider does not have a charge structure, the charge structure used by the servicing entity may be used to apportion costs if it provides for similar charges for similar services to both Medicare and non-Medicare patients. Charges so determined should be added to charges for services to Medicare patients and used to apportion costs in accordance with the apportionment method the provider is required to use under the program.

HCFA Pub. 15-1 ' 2314.B.

Respectively, the Intermediary determined that the Provider was unable to gross-up its costs and charges in accordance with the program=s rules. The Intermediary concluded that the data used by the Provider to gross-up its physical therapy department=s costs and charges would produce improper program payments when carried through the cost apportionment process. Specifically, the Intermediary found that when the Provider grossed-up its physical therapy costs using an $18.90 per unit cost, and grossed-up its physical therapy charges using a $10 per unit charge, the amount of physical therapy costs apportioned to Medicare exceeded the sum of the actual direct costs charged to that department plus the amount of indirect costs allocated thereto.

The Board also finds that it is improper for the Provider to use their grossing-up methodology to allocate overhead costs to its physical therapy cost center. In particular, the Board finds that the $10 per unit charge established by the Provider for the physical therapy/maintenance service does not comply with the definition of Acharges@ at 42 C.F.R. ' 413.53, which applies to cost apportionment. The regulation states:

> [c]harges means the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in

> the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

42 C.F.R. ' 413.53.

With respect to this matter, the Board finds that the Provider=s charge for physical therapy/maintenance does not relate to the cost of those services. While the Board acknowledges that some providers, usually in financially indigent areas, may deliberately set their charges at levels less than their costs, the Board does not find that circumstance existing in the instant case. Clearly, the Board would expect the Provider=s charge for physical therapy/ maintenance services to be greater than its cost if those services were actually furnished to Medicare beneficiaries.

The Board acknowledges the fact that the cost and charge data used by the Provider to gross-up the physical therapy/maintenance service does comply with HCFA Pub. 15-1 ' 2314.B, i.e., in accordance with the manual, the Provider used the same schedule of charges used by its therapy vendor to gross-up costs, and its own/actual standard charge structure to gross-up charges. However, the Board also finds that a provider=s compliance with HCFA Pub. 15-1 ' 2314.B does not, in and of itself, entitle that provider to use the grossing-up methodology.

Program instructions at HCFA Pub. 15-1 ' 2203, which pertain to cost apportionment, state in part:

> [w]hile the Medicare program cannot dictate to a provider what its charges or charge structure should be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

HCFA Pub. 15-1 ' 2203 (emphasis added).

Accordingly, the Board finds that the Provider=s charge statistic for physical therapy/ maintenance, when compared to its vendor=s charge for that service, may produce illogical results or improper program payments. Therefore, this charge statistic is unallowable for cost apportionment, and the Provider=s ability to use the grossing-up methodology is negated.

In its analysis of this case, the Board considered the Intermediary=s proposition to apply a $30.00 per unit charge to the Provider=s physical therapy/maintenance service in order to facilitate the Provider=s use of the grossing-up methodology. The Board also considered the Intermediary=s alternative Amark-up/mark-down@ approach, as well as various other methodologies that could be viewed as reasonable means for allocating overhead to the Provider=s physical therapy cost center. The Board concludes, however, that there is no substantive basis to any of these other propositions, and no assurance that they would result in a proper determination of program costs. Accordingly, the Board rejects any proposal to allocate overhead to the Provider=s physical therapy cost center.

DECISION AND ORDER:

The cost and charge data used by the Provider to gross-up its occupational and speech therapy cost centers is accepted. The Intermediary is to revise its cost report settlement to allow for the allocation and apportionment of overhead expenses through these cost centers. The cost and charge data used by the Provider to gross-up its physical therapy cost center does not comply with program rules and is rejected. No overhead expenses are to be allocated to/and reimbursed through this cost center. The Intermediary's adjustment is reversed in part, and sustained in part.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

**Date of Decision**: September 07, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman