PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D12

PROVIDER -
High Tech Home Health, Inc.
Palm Beach Gardens, FL

Provider No. 10-7281

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Palmetto GBA

DATE OF HEARING-
June 16, 2000

Cost Reporting Periods Ended -
December 31, 1994 and
December 31, 1995

INDEX

ISSUE:

FY 1994

1. Was the Intermediary=s adjustment to administrative and general (AA&G@) for the intake coordinator=s salaries proper?

2. Was the Intermediary=s adjustment to A&G staff expenses proper?

3. Was the Intermediary=s adjustment to administrative and general and physical therapy costs proper? (Administratively resolved and withdrawn at hearing (Tr. pp. 90-91).

FY 1995

1. Same as # 1 for FY 1994.

2. Was the Intermediary=s adjustment disallowing advertising costs proper? (Administratively resolved and withdrawn at hearing (Tr. pp. 91-92).

3. Was the Intermediary=s adjustment removing expenses from the cost report that were not actually incurred proper? [Parties relied upon materials in the record.]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

High Tech Home Health, Inc. (AProvider@) is a proprietary home health agency located in Palm Beach Gardens, Florida. The Provider served home health patients from three offices. The two offsite offices had an office manager who also performed other activities. Although its staff had job descriptions (AJD@), employees were cross-trained to perform other activities as needed.

The Provider=s initial fiscal intermediary was Aetna Life Insurance Company succeeded by Palmetto GBA located in Columbia, South Carolina (AIntermediary@) an affiliate of the Blue Cross Blue Shield Association. The Intermediary was responsible for 1) making payments to the Provider under Medicare=s Periodic Interim Payment (APIP@) System; 2) reviewing and paying claims for services provided, 3) reviewing and auditing annual cost reports to ensure the claimed costs are in compliance with Medicare law, regulation, and policies, and 4) determining the amount of reimbursement due to or from the Medicare program for a particular cost reporting year.

In prior years, the Intermediary (Aetna) made a variety of adverse adjustments which focused on inadequate documentation of claimed costs. For example, the Provider did not have adequate documentation to allocate the costs of Aintake coordinators@ (AIC@) because there were no time sheets

or other reliable documentation to support how their time was performed as between allowable and non-allowable activities. Some of the non-allowable activities focused on patient solicitation and marketing activities. The Intermediary felt the same problem continued for the years under appeal even though the Provider now maintained activity sheets (AAS@). They still did not indicate how much time was spent on the different activities -and- the activities were not detailed. For example, the AS might show Aphysician visit@ with no indication of: 1) the purpose, 2) what was discussed, or 3) the amount of time spent. In these instances, there was a 100% disallowance of the IC=s salary and related costs.

The Provider timely filed cost reports for fiscal years (AFY@) ended December 31, 1994 and 1995. The Intermediary reviewed and made field audits of these cost reports making several adjustments; and the Intermediary issued final notices of program reimbursement (ANPR@) stating that the Provider had been overpaid each FY.

The Provider was dissatisfied with the Intermediary=s reimbursement adjustments and determinations in the NPRs for the two FYs, and timely appealed to the Provider Reimbursement Review Board (ABoard@). The Board determined that the Provider has met the relevant regulatory requirements of 42 C.F.R. '' 405.1835-1841. The amount of Medicare reimbursement in controversy is about $352,800 for FY 1994 and $635,200 for FY 1995.

The Provider originally appealed fifteen (15) issues for FY 1994. However, 4 issues were dismissed for lack of Board jurisdiction; 9 issues were withdrawn; and 2 issues were presented at the hearing held on June 16, 2000. The Provider originally appealed five (5) issues for FY 1995. Two were administratively resolved, two presented at the hearing and was one heard on the record.

The Provider was represented by Thomas J. Larkin, Esquire, Executive Director of High Tech Home Health, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel of the Blue Cross and Blue Shield Association.

ISSUE 1 - Intake Coordinator Salary Costs -- FY 1994 and FY 1995:

FACTS:

In prior years, the Provider had experienced a large number of medical claim denials because of physicians= lack of completeness in their patient care plans. The Provider undertook an alleged educational activity with physicians by the intake coordinators in an effort to reduce/eliminate these denials. This activity occurred at the convenience of the physician, typically at lunch time with the Provider furnishing food at its expense. The lunches frequently were in the physician=s office with Atake-out@ food delivered.

The Intermediary disallowed 100% of the salary costs [and benefits] claimed for the intake coordinators

and other personnel in the amounts of $345,122 for FY 1994 and $180,146 for FY 1995 due to their performance in non-allowable marketing activities and for inadequate auditable and verifiable documentation. In 1994, the disallowance consisted of $345,122 in salaries and fringe benefits. In FY 1995, $151,912 in salaries and $28,234 in related benefits were disallowed which totaled $180,146. The estimated reimbursement effect was $337,012 for FY 1994 and $164,653 for FY 1995.

Through the audit process including interviews of staff, review of records, etc., the Intermediary determined that several employees were involved in non-allowable activities such as the solicitation of patients, marketing activities, and were otherwise seeking to obtain a competitive edge over other home health agencies (AHHA@). Although the Provider had newly developed AActivity Sheets@ (AAS@) for the staff in FY=s 1994 and 1995, the AS did not adequately identify specifics of an activity or include the amount of time spent to enable an apportionment of salary costs between allowable and non-allowable activities. In the absence of such documentation the Intermediary=s disallowance was typically 100% of the salaries and benefits of those involved.

PROVIDER=S CONTENTIONS:

The Provider makes the following contentions:

1. That the intake coordinators were engaged in allowable educational, liaison, and patient coordination activities specifically allowed by the regulations and the Provider Reimbursement Manual, HCFA Pub. 15-1 (APRM@).

2. That the Intermediary imposed stringent and unsupported record keeping requirements.

3. That the Intermediary impermissibly identified staff that had trivial contact with physicians and improperly disallowed 100% of their salary and related costs.

I

The Provider completely disagrees with the Intermediary=s determination. The Provider affirmatively asserts, as supported by hearing testimony, that the intake coordinators were only engaged in allowable educational, liaison, and other patient related activities; and that the coordinators did not engage in any non-allowable activities, such as solicitation.. (Tr. pp. 31-35).

The Provider maintains that the regulations and PRM specifically allow education and liaison activities that the staff was performing. The regulation provisions state in part:

> (a) Principle.
> ... Reasonable costs include all necessary and proper expenses incurred in furnishing the

services.

(b) Definitions--(1) Reasonable cost. Reasonable cost of any service must be determined in accordance with regulations ...

(2) Necessary and proper costs. ... are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are common and accepted occurrences in the field of the provider=s activity.

(c) Application. ***

(3) ... Reasonable costs includes all necessary and proper expenses incurred ... both direct and indirect ....

42 C.F.R. ' 413.9

The Provider asserts the Medicare statute at 42 U.S.C. ' 1395x(v)(1)(A) states that reasonable costs include costs appropriate and helpful in developing and maintaining the operations of patient care facilities and activities. Such costs are usually common and accepted occurrences in the field of the Provider=s activity. The Provider maintains the costs incurred met this criteria.

The Provider states the Health Care Financing Administration (AHCFA@) has also issued interpretive PRM manual provisions which state in part:

Educational and Liaison Activities

Education and liaison activities permit the HHA to establish ties with the rest of the health care system. These activities are allowable to the extent that they are necessary for patient care and do not duplicate services which are or should be performed by the hospital or SNF . . . . The activities include:

A. Serving as an educational resource to the hospital or SNF concerning home health services. This includes conducting training for hospital or SNF staff and serving as a consultant to the hospital or SNF for establishing home care policies and practices.

B. Educating physicians concerning the range of home care services available.

HCFA Pub. 15-1 ' 2113.2

The Provider notes that the intent of the educational efforts should not be targeted at specific patients, either directly or through their physicians, in an attempt to persuade the patient to request the particular HHA=s services. Another manual section provides:

Patient Solicitation Activity

Costs incurred by a home health agency for personnel performing duties in the hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes. . . Visits made by HHA personnel to patients which have not yet been referred to the HHA (as evidenced by the patients medical record) in order to persuade the patient to request the HHA=s services are considered patient solicitation; as would visits to physicians to obtain referrals. . . .

HCFA Pub. 15-1 ' 2113.3 (Emphasis added).

The Provider states the manual also addresses allowable patient coordinator activities which states as follows:

Home Health Coordination Activities

The cost of coordination activities, which ease the patients= transition from hospital or SNF to the home under the care of an HHA, are allowable. Coordination activities take place once the patient=s physician has determined that the patient requires home health services as evidenced by the patient=s medical record, and the specific HHA that is to render the services has been chosen by the patient and/or his family. Coordination activities are of the type listed below. They are allowable costs unless the activities are found to be unnecessary for patient care or a duplication of services already performed by the hospital or SNF ...

Coordination activities:

A. Explaining the agency=s policies to patients and responsible family members following referral.

B. Assisting in establishing a definitive home care plan prior to discharge, including assessment of the appropriateness of the requested services, medical supplies and appliances.

C. Assuring that the HHA is ready to meet the patients=s needs at the time of discharge. This entails making arrangements for any special medical supplies or appliances, making arrangements for training agency personnel regarding unfamiliar procedures or problems pertaining to the patient=s care, and communicating information regarding the patient to agency personnel.

HCFA Pub. 15-1 ' 2113.1 (Emphasis added).

The Provider asserts the intake coordinators were performing within the scope of the above stated provisions, i. e., education and liaison. The Provider states that due to the Intermediary=s high rate of medical denials, the Intermediary advised it was the Provider=s responsibility to interrelate with the

physician. The Provider=s educational activity took place at lunch time at the physical=s office while also providing lunch. The Provider notes the Intermediary position that the regulations prohibits furnishing meals to physicians, but disagrees with the assertion that the entire activity must be disallowed.

The Provider claims the Intermediary=s challenge to their Aeducational@ methodology was too broad and improper. First, the Intermediary challenged the furnishing of meals to physicians as being unallowable (HCFA Pub. 15-1 ' 2105.2); secondly, the Intermediary determined that the entire staff activity to the physician offices at lunch time was also tainted ultimately resulting in a 100% disallowance of the intake coordinator=s [and others] salary and related expenses. The Provider asserts that there is a disproportionate effect involved with the alleged non-allowable lunch activity. That in FY 1994, the disallowance of $16,000 of lunch expense also resulted in a disallowance of $345,000 in salary and related costs which is unreasonable. The Provider asserts there was sufficient documentation to support the fact the intake coordinators were substantially engaged in allowable activities which was improperly rejected or ignored by the Intermediary, such as QA documentation, etc. . In fact, the staff maintained a daily AActivity Sheet@ showing substantial allowable activities which the Intermediary rejected (as discussed below).

II

The Provider contends that the Intermediary imposed stringent documentation requirements that were unsupported. The Provider asserts the Intermediary can not require documentation beyond an institution=s basic accounts as usually maintained, consistent with good business concepts and effective and efficient management of any organization. High Tech v. Shalala, Case No. 96-8726-CIV-HURLEY. Further, the Intermediary has ignored documentation of the Provider while demanding other documentation which was impossible to meet after the fact. (PH-B p. 5).

The Provider asserts it is a very low cost HHA, and it is much lower than most HHA=s in the Intermediary=s jurisdiction which has been completely ignored.

The Provider takes issue with the Intermediary=s position of making a 100% denial of the salaries when its own witness admitted that the staff did some allowable activities. (Tr. pp. 62-65). The Provider asserts it had developed an AActivity Sheet@ (AAS@) approved during a meeting with the Intermediary after the FY 1993 audit; but now, after the fact, the Intermediary finds the AS deficient because it does not show any Atime intervals@ which had never been previously discussed or required by the Intermediary. (Tr. p. 89) The Provider asserts the AS even with its deemed imperfections could be used to identify allowable time vs the 100% disallowance. For example, some effort should have been made to assign time to the deemed non-allowable Alunch educational@ activity and allowing all other time. The Provider asserts the alleged non-allowable activity was only a small portion of the total staff time, like 3 or 4 days out of a month. The Provider claims the Intermediary had no proof of solicitation activities in either FY 94 or 95; and no adjustments made to the intake coordinators salaries in FYs

1990-1992 even though there were no AS or time sheets.

III

The Provider contends that it was improper for the Intermediary to disallow any staff person having some contact with physicians because such contacts were only remotely involved. The Provider states that since it was a small business, it was necessary for-- 1) some position descriptions to overlap, 2) cross-training, and 3) to the extent possible, staff was expected to perform other duties and functions to accomplish the tasks of the agency. (Tr. p. 33-34). For example, two persons who had nursing backgrounds were the managers of two offsite offices whose prime responsibility was to manage, perform quality assurance (AQA@) work, educate all staff including the nurses and others who performed the HHA visits. The Provider asserts that since the two managers also had infrequent contacts with physicians, the Intermediary then improperly considered their entire salary and benefits as tainted with a 100% disallowance. The Provider states these individuals had considerable documentation regarding other activities performed, such as QA, demonstrating the majority of their time was spent on allowable activities which was ignored by the Intermediary.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Provider failed to present adequate auditable documentation to support the claimed salary and related costs of various personnel involved in the intake coordinator function as required by the Medicare regulations at 42 C.F.R. '' 413.20 and 413.24, and the HCFA Pub. 15-1 ' 2304ff. The Intermediary contends it is the Provider=s responsibility to maintain adequate documentation to permit allocations between allowable and non-allowable activities. The Intermediary asserts it can not arbitrarily assign time or percentages without appropriate documentation which was not furnished or available..

I

The Intermediary contends that the Provider failed to maintain adequate auditable documentation as required by the regulations at 42 C.F.R. '' 413.20 and 413.24. The supporting documentation must be auditable and verifiable; and where non-allowable activities are involved, there must be documentation to determine what portion is allowable or non-allowable. It is the Provider=s burden and responsibility to maintain documentation demonstrating the amount of time or percentage that is allowable or non-allowable. It is not the Intermediary=s responsibility to develop some arbitrary time for allowable activities as suggested by the Provider.

The Intermediary disagrees with the Provider=s assertion and testimony that its staff was solely involved in allowable educational and liaison activities. The Intermediary=s witness testified that the best evidence was documentation that permits tracking, like time logs. (Tr. p. 63) The Intermediary audit of the

available records in FY 1994 and FY 1995 revealed that staff was involved in non-allowable solicitation of patients and other marketing activities. It was determined that some staff members had prior marketing experience and their job descriptions (AJD@) called for marketing activities such as the manager at the Port St. Lucie office. (Tr. p. 87)

The Intermediary states specific individuals were identified as being involved in solicitation and marketing activities which included a wide range of persons such as the managers of offsite offices and others who participated in the intake function.

II

The Intermediary asserts it did not require more stringent record keeping requirements as alleged by the Provider. The regulations require providers to maintain adequate financial data. The regulation states in part:

(a) General. The principles of cost reimbursement require that providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

***

(c) Recordkeeping requirements for new providers.
(1) The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes ....

(d) Continuing provider recordkeeping requirements. (1) The provider must furnish such information ... as may be necessary to--
(i) Assure proper payment by the program ...
(2) ... to ascertain information pertinent to the determination of the proper amount of program payments due.

42 C.F.R. ' 413.20

The Intermediary disagrees with the Provider=s bare assertion that they must accept the records it maintained. The Intermediary states the records must meet the basic requirement of enabling the determination of what amounts of the claimed costs are payable under the program, i.e., allowable, per 42 C.F.R ' 413.20.

The Intermediary states the Provider=s new AS maintained for both FYs 1994 and 1995 were deficient

because it did not contain any time spent on a particular activity, nor did it sufficiently describe or detail what occurred in each activity. Therefore, the AS was inadequate and unverifiable as to what an individual actually performed or how long an activity lasted. For example, the AS may show a visit by an intake coordinator to a doctors office; but, it did not show the amount of time spent or exactly what the visit might entail. There was no detail of what transpired at the meeting because the AS failed to show any detail and there was no other supporting documentation, such as an agenda or identification of any particular patient records or medical denials, etc. to show what was discussed. The Intermediary asserts there was nothing to support the claim of a proper educational or liaison activity nor any time shown permitting an allocation between allowable and non-allowable activities.

The Intermediary also states there were problems with the AS interrelating with other records maintained. For example, the auditors were unable to reconcile the mileage logs with the AS or other documents. The visit logs did not show time spent and there were also discrepancies in the mileage logs.

The Intermediary claims other records maintained by the Provider were not supportive of any allocation, e.g., the QA records and patient visit records did not show the amount of time spent.

III

The Intermediary claims once a staff person was required to travel as part of their duties, it was then necessary for the Provider to maintain adequate verifiable records concerning the nature and time spent on the various performed activities. The Intermediary maintains incidents were found of staff performing unallowable activities. The Intermediary states the burden was upon the Provider to maintain adequate verifiable records permitting an allocation between allowable and unallowable activities which was not done by the Provider in the years under appeal. In the absence of such records, the Provider did not maintain its burden which resulted in a 100% disallowance.

ISSUE NO. 2 - 1994: A&G Staff Expenses related to AEducational@ costs:

FACTS:

The Provider claimed two types of AEducation@ expenses: ATravel@ and AOther@ which were primarily related to the physician education visit activity in Issue No. 1 above. The Intermediary determined the physician visits were a non-allowable solicitation activity and unrelated to patient care due to inadequate documentation, i.e., no documentation regarding the purpose, or an agenda of topics discussed, etc. The Intermediary disallowed $5,207 of ATravel@ and $ 11,003 of AOther@ or a total of $16,210 which had a reimbursement effect of $15,829.

Within the ATravel@ category, the Intermediary disallowed $3,208 for non-allowable travel out of the

country which was determined not to be reasonable or necessary; and $1,999 disallowed for inadequate documentation. The AOther@ category was disallowed because it was directly related to the non-allowable physician visit activity and consisted primarily of food for the physicians.

PROVIDER=S CONTENTIONS:

The Provider contends the claimed AEducational@ costs [both ATravel@ and AOther@] were properly allowable under the provisions of HCFA Pub. 15-1 ' 2113.2, Educational and Liaison. This manual section permits the Provider to have ties with the health care system. The Provider avers that in view of the numerous medical denials by the Intermediary, it was necessary to obtain access to the physicians to educate them about the deficiencies being encountered. Moreover, the Intermediary stated it was the Provider=s responsibility to make necessary contacts with the physicians about these denials. The Provider maintains that the physicians would not provide time other than lunch time; and that the food cost was very nominal and reasonable. Therefore, both the travel and food costs should be allowable since they were reasonable and necessary.

The Provider states the Intermediary improperly denied the travel costs to San Juan, Puerto Rico for attendance at a NAHC conference on Health Care Reform: Managing Change. The Provider asserts this was clearly an educational program ordinarily allowable by the Medicare program.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends it determined the Provider=s alleged physician educational activity to be a non-reimbursable solicitation activity per Issue No. 1 above. The Intermediary avers that the manual provisions state, in part:

> Visits made by HHA personnel to physicians to obtain referrals are considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include ... costs for meals, entertainment, etc., ...

HCFA Pub. 15-1 ' 2113.2

The Provider failed to maintain adequate documentation demonstrating this activity was allowable as it contended, such as agendas, rosters, patient records, problems, etc to show course content or matters discussed. Thus, the cost of meals reported as AEducational - Other@ were disallowed ($11,003).

The costs claimed as AEducational - Travel@ was disallowed for 1) inadequate documentation ($1,999), and for 2) non-allowable travel out of the country considered unreasonable and unnecessary ($3,208).

ISSUE 3 - FY 1994
AND
ISSUE 2 - FY 1995

These issues were administratively resolved and withdrawn at the hearing (Tr. pp. 90-92).

ISSUE 3 - FY 1995: -- Removal of Costs Not Actually Incurred-Legal Expenses:

FACTS:

The Provider alleges that due to Aetna=s actions, it is no longer participating in the Medicare program. In the FY 1995 cost report, the Provider claimed $500,000 for legal expenses that would be incurred in the future for litigating Medicare appeals. The Provider is currently litigating two appeals in US District Courts of Florida, one in the US Court of Appeals for the Eleventh Circuit, and is pursuing the two appeals of FY=s 1994 and 1995 at the Board. Ordinarily, reasonable legal fees incurred and liquidated for these types of cases are generally allowable.

PROVIDER=S CONTENTIONS:

The Provider maintains that even though it is no longer doing business with Medicare, there is a continuing involvement relating to the legal pursuit of various appeals in courts and to the Board. Absent any cash flow from Medicare, there is no way to liquidate the legal liabilities being currently incurred or to continue litigating the appeals. Therefore, since legal fees for this type of litigation are generally allowable, then the Intermediary should provide reimbursement for the legal fees as they are incurred for these appeals in later years.

The Provider contends this issue relates to Aaccrual vs cash@ accounting. The Provider is entitled to accrue the cost of legal expenses, and the denial thereof is a violation of the law permitting the use of accrual accounting per the Medicare statute and PRM-1 ' 2302 et seq. The Provider also contends this denial also violates the due process provisions of the 5th Amendment to the US Constitution because its effect is a denial of access to the appellate process.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its disallowance of the claimed $500,000 was proper because::

1. the Provider had not incurred the projected legal fees claimed in the FY 1995 cost report;

2. the Provider had not documented that the claimed legal costs was a proper expense incurred in accordance with 42 C.F.R. ' 413.9 and 413.24 nor timely liquidated pursuant to PRM-1 ' 2305.

The Intermediary contends the Provider has not cited any legal authority for its position nor is there any legal authority to pay for projected and contingent legal fees of a non-participating provider in the future.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTIONS:

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

' 1395x(v)(1)(A)	-	Reasonable Cost

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

'' 405.1835-1841	-	Board Jurisdiction
' 413.9 et seq.	-	Cost Related to Patient Care
' 413.20 et seq.	-	Financial Data and Reports
' 413.24 et seq.	-	Adequate Cost Data and Cost Finding

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

' 2105.2	-	Cost of Meals for Other Than Provider Personnel
' 2113 et seq.	-	Home Health Education and Liaison; Home Health Coordination Costs; Patient Solicitation Activities
' 2302 et seq.	-	Adequate Cost Data and Cost Finding; Definitions
' 2304 et seq.	-	Adequacy of Cost Information

' 2305 et seq. - Liquidation of Liabilities

4. Cases:

High Tech Home Health, Inc. v. Shalala, U.S. D.C. Southern Dist. of FL, Case No. 96-8726-CIV-HURLEY.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, the facts, parties= contentions, testimony and evidence presented, finds and concludes as follows:

Issue No. 1 for 1994 and No. 1 for 1995 - Intake Coordinator Salaries and Related Costs:

After reviewing and considering the entire record, the Board finds that the Provider has not provided substantial evidence in support of its position that the intake coordinator salaries and related costs should be allowable. The Intermediary=s adjustments are sustained.

The Board finds that:

1. HCFA Pub. 15-1 ' 2113 et seq, provides that Educational and Liaison activities are an allowable costs, but Patient Solicitation is not allowable.

2. Patient solicitation includes visits to patients, physicians, hospitals and nursing homes for the purpose of persuading the party contacted to make referrals to the Provider.

3. The Intermediary=s witness and other evidence, such as job descriptions, demonstrated that some marketing and/or solicitation activity existed. Hence, the burden was upon the Provider to maintain documentation separating these activities from allowable activities.

4. There was conflicting testimony and evidence concerning the Provider=s position that all the intake coordinator (AIC@) salaries were allowable.

5. a) Although there was some testimony and evidence that the IC were performing substantial allowable activities, the record had insufficient documentation to enable any reliable allocation. b) Despite the ambiguity in the record, the Provider failed to present adequate documentation to support its position obviating other alternatives. c) The Board=s requested data from the Provider in the post-hearing brief was not creditable or of any assistance.

6. The core problem in this case was the lack of documentation.
a) There was no statistical data available in the record to support either a meaningful allocation of the IC

salary/time or the Provider=s position that all salaries were allowable.
b) The IC=s Activity Sheets (AAS@) did not show the amount of time spent on a particular activity nor did it contain a sufficient description of what actually occurred, particularly the alleged educational visits to the physicians. There was no detail or other related documentation to support the Provider=s assertion that only educational and liaison activities were performed.

The Board notes that in view of the substantial allowable activities performed, the Intermediary=s audit could have taken a different approach. The purpose of a hearing is to determine whether there is adequate information in the record to substantiate the Provider=s position, but there is none in this case. The burden of proof was upon the Provider which was not met.

7. Under the regulations at 42 C.F.R. '' 413.20 and 413.24, a provider has the burden of maintaining adequate documentation to support its claimed costs and enable the intermediary to determine the amount payable. The manual requires time logs and other supporting records to substantiate what the IC were doing including the allowable time spent by the IC which the Provider failed to maintain. As already stated in 6 a) above, the newly maintained AS were insufficient to enable a pure statistical allocation of time.

8. In the absence of adequate and verifiable contemporaneous records to support the Provider=s position of allowing all the IC salary and related costs; and since there were no records to afford a meaningful allocation between allowable and non-allowable activities, the Intermediary=s adjustments of a 100% disallowance of salaries and related costs are affirmed.

Issue No. 2 for 1994 - A&G Staff and Educational Costs unrelated to Patient Care:

The Board finds after a review of the entire record that the Intermediary=s adjustment to eliminate educational costs related to unallowable activities and/or unrelated to patient care was properly made in accordance with the Medicare regulations and, program instructions. The adjustments are affirmed.

Issue No. 2 for 1995 - Removal of Costs not actually incurred:

The Board finds after a review of the entire record that the Intermediary=s removal of costs not incurred or liquidated for the FY 1995 cost report pertaining to future legal fees was proper. The adjustment is affirmed.

DECISION AND ORDER:

Issue No. 1 for FYs 1994 and 1995 - Intake Coordinator Salaries and Related Costs:

The Provider has not provided substantial evidence to support its position that all of the Intake

Coordinator salary and related costs are allowable. The Intermediary=s adjustments are affirmed.

Issue No. 2 for FY 1994 - A&G Educational Costs:

The Provider has not provided substantial evidence to support its position that the educational costs related to a non-allowable activity or determined not reasonable and necessary should be allowable. The Intermediary=s adjustments are affirmed.

Issue No. 2 for FY 1995 - Removal of non-incurred costs:

The removal of future legal costs not incurred or liquidated for the FY 1995 cost report was proper. The Intermediary=s adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

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

Date of Decision: Feb. 21, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman