PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D28

PROVIDER –
Hoag Memorial Hospital Presbyterian
Newport Beach, California

Provider No. 05-0224

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/ United Government Services, LLC - CA

DATE OF HEARING-
March 2, 2000

Cost Reporting Period Ended
September 11, 1993

CASE NO. 96-1240

INDEX

ISSUES:

1. Was the Intermediary's treatment of cell biology laboratory expense and revenue proper?

2. Was the Intermediary's determination of reimbursable Medicare bad debts proper?

3. Was the Intermediary's treatment of the rental expenses for the nursing administration and OB education departments proper?

4. Was the Intermediary's determination of nonreimbursable costs for the unused space cost center proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hoag Memorial Hospital Presbyterian (Provider) is a 416 bed acute care hospital located in Newport Beach, California. On September 15, 1995, the United Government Services, LLC - CA (Intermediary) issued a Notice of Medicare Program Reimbursement for the Provider's cost reporting period ended September 11, 1993. On March 11, 1996, the Provider filed a request for hearing to appeal certain of the Intermediary's adjustments to the Provider Reimbursement Review Board (Board). The Provider's filing meets the requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Thomas J. Weiss, Esquire. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

Issue No. 1 - - Cell Biology Costs and Revenues

Facts:

During the audit of the Provider's cost report, the Intermediary determined that the costs of the Provider's oncology laboratory and cell biology laboratory departments were not related to patient care. As a result, the Intermediary applied audit adjustment number 3 which reclassified the following costs from the oncology cost center to the non-reimbursable research cost center:

Dept #	Department	Amount
7495	Oncology Laboratory	$264,489
7497	Cell Biology Laboratory	562,309
	Total Amount Reclassified	$826,798

On October 28, 1996, in response to the submission of additional documentation and the Provider's request for reopening, the Intermediary reopened the cost report to reclassify the costs of the oncology laboratory department back to the oncology cost center. The Intermediary did not revise its determination regarding the cell biology laboratory department. Costs of the cell biology laboratory remained in the non-reimbursable research cost center. The Provider disputes several aspects of the Intermediary's treatment of the cell biology laboratory department. The Intermediary's adjustment resulted in a reduction in Medicare reimbursement of approximately

$336,000.

PROVIDER'S CONTENTIONS:

Regarding the amounts reclassified to nonreimbursable cost centers, the Provider contends that the cell biology laboratory expenses reclassified to the research cost center are excessive. They are not properly adjusted to reflect the application of the building and equipment rental expense reclassification on Worksheet A-6 of the Medicare cost report. Departmental costs reclassified to nonreimbursable cost centers must be reduced for amounts that have been reclassified to other cost centers through other Worksheet A-6 reclassifications. The workpaper supporting the reported reclassification of rental expense[1] indicates that oncology expenses were reduced by $3,146 for cell biology laboratory rental expenses on Worksheet A-6. Consequently, cell biology laboratory costs reclassified to the research cost center must by reduced by this amount.

Regarding revenues included on Worksheet C of the Medicare cost report used in apportioning costs to Medicare, the Provider contends that gross revenues for the oncology cost center are overstated because they include gross revenues for the cell biology laboratory department. Gross revenues reported on Worksheet C for the oncology cost center include $677,080 of cell biology laboratory department revenues recorded in account number 4497.[2] Since the costs of the cell biology laboratory department have been reclassified from the oncology cost center to the non-reimbursable research cost center, it is inappropriate to include the revenues for the cell biology laboratory department in the oncology cost center for purposes of apportioning allowable costs between Medicare and non-Medicare patients.
42 C.F.R. §413.53 states:

> 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. (Emphasis added).

Since the charges for the cell biology laboratory are not related to the costs of services reported in the oncology cost center, they must be removed from reported charges for the oncology cost center on Worksheet C.

Finally, the Provider contends that its evidence on this issue was unrebutted, and there is nothing in the record which could support a decision by the Board inconsistent with the Provider's

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1 See Provider Exhibit E.

2 See Worksheet C and supporting revenue grouping schedule showing revenues for cell biology laboratory are included in oncology revenues at Exhibit D.

position.

INTERMEDIARY'S CONTENTIONS:

The Intermediary offers no contentions.

Issue No. 2 - Medicare Crossover Bad Debts

Facts:

The Provider claimed $356,000 for Medicare/Medicaid crossover claims as Medicare Part B bad debts. In order to determine the allowability of these amounts, the Intermediary reviewed selected crossover bad debt files using patient files. Because the Provider's information was incomplete, the Intermediary asked the Provider to supply the following information:

- A revised patient list that includes HIC number, recovery, deductible and coinsurance amounts.

- Copies of medical cards, as well as the Medicare remittance advices for the selected 10% sample for review.

Although the Provider subsequently supplied the Intermediary with its bad debt crossover list, the list did not contain the information that the Intermediary had requested. Furthermore, the Provider failed to furnish copies of the medical cards and Medicare remittance advices.

The Intermediary made an adjustment disallowing the Provider's crossover bad debts. These bad debts were disallowed for the following reasons:

- inconsistency in the Provider's billing practices
- the crossover list did not separate deductibles and coinsurance
- the crossover list did not report recovery amounts for verification

Subsequently the Provider did provide an updated listing of Medicare crossover bad debts amounting to $117,140.[3]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's determination improperly excludes $117,140 of reimbursable Part B Medicare bad debts for beneficiaries who were also eligible for Medi-Cal benefits.[4] The amounts in question meet the criteria set forth at 42 C.F.R. §413.80 and therefore

[3] See Provider Exhibit K.

[4] Id.

should be reimbursed as Medicare bad debts. In accordance with 42 C.F.R. §413. 80(e)(1), all of the listed accounts relate to deductible and coinsurance amounts for covered hospital services. Further, in accordance with 42 C.F.R. §413.80(e)(2), reasonable collection efforts were made. The Provider verified the beneficiaries' eligibility under the Medi-Cal Program. Under the California State Plan, the Medi-Cal Program was responsible for the coinsurance and deductible liabilities of Medicare patients who were also covered under the Medi-Cal Program. However, upon verifying the patients' eligibility under the Medi-Cal Program, the Provider determined that the amounts in dispute were uncollectible and wrote them off as bad debts. The Provider's determinations were made based on the knowledge that amounts billed to the Medi-Cal Program would go unpaid due to Medi-Cal payment ceilings because payments were limited to the lower of:

1) the amount by which applicable Medi-Cal reimbursement rates for covered services exceeded Medicare payments, or

2) the amount of coinsurance and deductible.

See, California Welfare and Institutions Code § 14109.5[5] and California Code of Regulations § 51005(a)(2).[6]

The Provider notes that because the applicable Medi-Cal reimbursement rates for outpatient hospital services were lower than Medicare payments received by the hospital, no amounts were collectible from the Medi-Cal Program. Additionally, under the provisions of §51002 of the California Code of Regulations[7], the Provider was precluded from applying further collection efforts against beneficiaries who were eligible under the Medi-Cal Program. Consequently, rather than going through the futile exercise of billing the Medi-Cal Program for amounts that were uncollectible, the Provider recognized that the cost of further collection efforts was not justified. Despite not having billed the Medi-Cal Program for amounts that would not be paid, the amounts in dispute meet the requirements for reimbursable bad debts. Under the provisions of HCFA Pub. 15-1, §322, the unpaid Part B coinsurance and deductible amounts for Medicare Part B crossover patients due to a "State payment ceiling" are includable in the determination of reimbursable Part B bad debts. Specifically, §322 states:

> In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling." ... In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be

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5 See Provider Exhibit L.

6 See Provider Exhibit M.

7 See Provider Exhibit N.

> included as a bad debt under Medicare, provided that the requirements of §312 are met. (Emphasis added)

Since the amounts in dispute were determined to be uncollectible with the knowledge that the payment ceilings applied by the State would preclude payment of billed amounts, the amounts are includable in the proper determination of Part B bad debts.

The Provider observes that as required by 42 C.F.R. §413.80(e)(3) and §413.80(e)(4), the accounts were actually uncollectible when claimed as worthless and sound business judgement established that there was no likelihood of recovery at any time in the future. While the Medi-Cal Program was responsible for the Medicare coinsurance and deductible liabilities of crossover patients, the Medi-Cal payment policy precluded payment for crossover coinsurance and deductible amounts.

The Provider contends that the Intermediary erroneously excluded the crossover bad debts of approximately $356,000. These amounts were Medicare coinsurance amounts. The Provider has been able to document at least $117,945 of these crossover bad debts. As a matter of law, the Medi-Cal Program was not required to pay these amounts under the authority of Beverly Community Hospital v. Shalala, 132 F.3d 1259 (9th Cir. 1997).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its determination was made in accordance with the instructions contained in 42 C.F.R. §§ 413.20 and 413.24, and HCFA Pub. 15-1 §§ 2300, 2304ff and 2404.2. At the time of audit the Provider lacked documentation to support its claimed Medicare bad debt amount. Therefore, absent verifiable data, the Intermediary was correct in relying on the information that was available at the time of its review of the Provider's cost report.

The Intermediary observes that the Program regulations and instructions referenced above explicitly require the Provider to maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited, and in sufficient detail to accomplish the intended purpose.

The Intermediary states that it properly made the adjustment in dispute because it did not have a basis to allow the claimed Medicare bad debts, pursuant to 42 C.F.R. § 413.80 and HCFA Pub. 15-1 § 308. Specifically, the Provider must support:

- the reported amounts relate to covered services and are derived from deductible and coinsurance amounts, pursuant to HCFA Pub 15-1 §§ 302.5, 304 and 306,

- its collection efforts were reasonable and properly documented, pursuant to HCFA Pub. 15-1 § 310,

- it deemed the claimed amounts worthless because these amounts were actually uncollectible, and it did not have any basis to recover these debts in the future, pursuant to HCFA Pub. 15-1 § 310.2,

- its basis for determining the beneficiary's indigent status was in accordance with HCFA Pub. 15-1 § 312,

- it has properly accounted for the bad debts and subsequent recovery of bad debts in accordance with HCFA Pub. 15-1 §§ 314 and 316, and

- it has properly determined the Medicare bad debts under the State Welfare Programs, pursuant to HCFA 15-1 § 322.

Absent this documentation, the Intermediary does not have a basis to revise its determination or adjustment.

Issue No. 3 - Building Rental Costs

Facts:

During the audit of the Provider's cost report, the Intermediary determined that the following amounts reclassified to the Old Capital Related Costs - Building & Fixtures cost center did not constitute capital related rental costs.

Dept #	Department	Amount
8740	Nursing Staff Development	$49,603
7440	OAS - O.B. Education	52,589
	Total Amount Reclassified	$102,192

This resulted in a reduction in Medicare reimbursement of approximately $8,000.

PROVIDER'S CONTENTIONS:

The Provider contends that the amounts it reclassified on the filed cost report for Nursing Staff Development and OAS-OB Education are building rental costs and therefore should be treated as capital related costs under 42 C. F. R. §413.130. In reviewing the Intermediary's workpaper[8] supporting adjustment number 9, the Provider is unclear as to the basis for the adjustment. The workpaper states:

[8] See Provider Exhibit G.

> Per Provider's rental expense schedule, the CC is mis-classed as rentals.

However, the Provider's lease carry-forward schedule[9] clearly indicates that these two departments shared leased space at 351 Hospital Road, Suite 207. Accordingly, the cost related to the leased space should be treated as capital related costs.

The Provider contends that the uncontested evidence is that the auditor made an erroneous determination to exclude $52,589 rental paid. The auditor erroneously had concluded that a workpaper notation of the Provider referred to this rental amount as an error. In fact, however the reference was to an entry for service costs for lithotripsy services, which error had already been corrected.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its audit adjustment is consistent with the Provider's own records and the cost finding instructions and documentation requirements contained in 42 C.F.R. §§ 413.24, 413.130 and HCFA Pub. 15-1 § 2304.

In its position paper, the Provider stated the following:

> The Provider contends that the amounts it reclassified on the filed cost report are building rental costs and therefore should be treated as capital related costs under 42 C.F.R. § 4I3.130.

In response, the Intermediary wishes to point out that the Provider has not furnished sufficient information and documentation to support the disputed amounts, as required by 42 C.F.R. §§ 413.20, 413.24, and HCFA Pub 15-1 §§ 2300, 2304ff and 2404.2. These Program regulations and instructions explicitly instruct the Provider to maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited, and in sufficient detail to accomplish the intended purpose. Absent such documentation, the Intermediary lacks a basis to revise its determinations or adjustments.

The Intermediary also contends that the Provider did not demonstrate with convincing or compelling evidence that any of the documents relied upon by the Intermediary during the audit were inaccurate, erroneous or unacceptable for cost reporting purposes.

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[9] See Provider Exhibit H.

Issue No. 4 - Unused Space

Facts:

The Provider closed the nursing units on the tenth floor in order to implement a more efficient use of hospital space and resources. The tenth floor remained available in the event that occupancy rates returned to previous levels.

The Intermediary disallowed the direct and indirect costs associated with the unused tenth floor. The Provider objects to the Intermediary's adjustment for the following reasons:

- The costs associated with the vacant space on the tenth floor constitute normal standby costs under 42 C.F.R.§ 413.9.

- The costs allocated to the Unused Space cost center are excessive.

The adjustment in dispute results in a reduction in Medicare reimbursement of approximately $22,000.

PROVIDER'S CONTENTIONS:

The Provider contends that the costs associated with the vacant space on the tenth floor constitute normal standby costs under 42 C.F.R. §413.9. In addition, the costs allocated to the unused space cost center by the Intermediary are excessive. Regarding allowable standby cost, due to the declining occupancy of hospital beds, the Provider closed the nursing units on the tenth floor in order to implement a more efficient use of hospital space and resources. While closed, the tenth floor remained available in the event that occupancy rates returned to previous levels. Furthermore, any costs attributable to the tenth floor in FY 93 were unavoidable since it was part of the hospital tower addition which was constructed in 1974. As such, costs attributable to the tenth floor should be treated as allowable standby costs.

The Provider states that costs attributable to standby services are allowable under 42 C.F.R. §413.9 which states:

> Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs . . . It includes both direct and indirect costs and normal standby costs. (Emphasis added)

The Provider contends that even if the establishment of the unused space cost center were appropriate, the cost allocations applied by the Intermediary are excessive and not in accordance with 42 C.F.R. §413.24. Among the costs allocated to the unused space cost center by the Intermediary were:

Administrative & General
Maintenance and Repairs
Operation of Plant
Housekeeping

Utilization of these services by unused areas would be minimal to non-existent. Yet, the allocations made to the unused space cost center are equivalent on a per square foot basis to occupied cost centers which operate on a 24 hour basis. To illustrate the distortion of the cost finding process created by these allocations, the unused space cost center received higher allocations of maintenance and repairs, operation of plant, and housekeeping costs than the ICU and CCU cost centers combined. Clearly, usage of the services in question by the unused tenth floor could only be a fraction of the services used by the ICU and CCU cost centers which provided 24 hour intensive care over an occupancy of 8,000 patient days.

The Provider further contends that to the extent these services were provided to the tenth floor, they would represent the minimum amount of service required to maintain the facility and therefore constitute normal standby costs. Consequently, allocations from these cost centers to the unused space cost center are inappropriate.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider states that the costs involved were normal "standby costs" that are reimbursable in accordance with 42 C.F.R. §413.9. This section states that reasonable cost includes all necessary and proper expenses incurred in furnishing services, plus it includes both direct and indirect costs and normal standby costs. The Intermediary maintains that costs associated with unused space are not related to patient care and, therefore, are not considered allowable under 42 C.F.R.§ 413.9 and HCFA-Pub. 15-1, §§ 2102.1 and 2102.3.

The Intermediary observes that in the alternative, the Provider argues that even if the establishment of the unused space cost center is proper, the cost allocations applied by the Intermediary are excessive. The Intermediary points out that at the time of audit, the Provider lacked documentation to support the square footage statistics that it reported in its cost report. Therefore, absent verifiable data, the Intermediary was correct in relying on the information that was available at the time of its review of the Provider's cost report.

The Intermediary also argues that the Provider has failed to demonstrate that the Intermediary's treatment results in an overallocation of cost to the unused space. The Provider's preliminary position paper did not include any documentation to support its position.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.53	-	Determination of Cost of Services to Beneficiaries
§ 413.80 et seq.	-	Bad Debts, Charity and Courtesy Allowance
§ 413.130	-	Introduction to Capital - Related Costs

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

§ 302.5	-	Deductible and Coinsurance Amounts
§ 304	-	Bad Debts Under Medicare
§ 306	-	Bad Debts Relating to Non-Covered Services or to Non-Beneficiaries
§ 308	-	Criteria for Allowable Bad Debt
§ 310, et seq.	-	Reasonable Collection Effort
§ 312	-	Indigent or Medically Indigent Patients
§ 314	-	Accounting Period for Bad Debts
§ 316	-	Recovery Of Bad Debts
§ 322	-	Medicare Bad Debts Under State Welfare Programs
§ 2102.1	-	Reasonable Costs
§ 2102.3	-	Costs Not Related to Patient Care
§ 2300	-	Principle
§ 2304ff	-	Adequacy of Cost Information

§ 2404.2 - Examination of Pertinent Data and Information

3. Other:

California Code of Regulations:

§ 51002 - Beneficiary Billing

§ 51005(a)(2) - Other Health Care Coverage

California Welfare and Institutions Code

§ 14109.5 - Limitation on Reimbursement Rates for Medicare – Related Costs

4. Cases

Beverly Community Hospital v. Shalala, 132 F.3d 1259 (9th Cir. 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, facts, parties' contentions, evidence submitted and post-hearing briefs, finds and concludes as follows:

Issue No. 1 -- Cell Biology Costs and Revenues

The Board finds that the Provider's arguments are persuasive, reasonable and unrefuted. The regulations at 42 C.F.R. § 413.53 require a proper apportionment of costs based on the ratio of departmental costs to departmental charges. The above regulation also requires that charges should be related to the cost being apportioned to Medicare. The Provider argues that since the cell biology laboratory costs were removed from the oncology cost center, related charges should likewise be removed from that cost center's charges. This argument is logical and reasonable. Furthermore, the Intermediary neither refuted the Provider's position nor did it support its adjustment to include the cell biology lab revenue in the oncology cost apportionment process. Thus, the Board concludes that the Provider's request to remove the above revenue from the apportionment process is appropriate.

Issue No. 2 -- Medicare Crossover Bad Debts

The Board finds that the evidence submitted by the Provider supporting $117,140 of Medicare crossover bad debts is reasonable and acceptable for reimbursement to the Provider. Provider Exhibit K basically satisfies the Intermediary's concerns regarding: (1) the need for acceptable verifiable data, (2) that the billings were actually uncollectible, (3) that the patients were indigent

and (4) that a proper determination of Medicare bad debts was made under California's welfare program. The Board notes that the Provider was justified in not billing Medicare beneficiaries for Medi-Cal services because §51002 of the California Code of Regulations limiting payments to Medi-Cal payment ceilings makes collections from Medicare/Medi-Cal patients futile. The Board further finds the remaining $238,860 of crossover bad debts are unsupported and undocumented. They are therefore not allowable. The Board concludes that only $117,140 of Medicare crossover bad debts are allowable, and the Intermediary's adjustment is modified accordingly.

Issue No. 3 - - Building Rental Costs

The Board finds that based on the evidence submitted, the Provider's reclassification of rental costs related to the Nursing Staff Development and OAS and OB Education Departments as capital related costs is correct. Thus, the Board concludes that the Intermediary incorrectly removed the rental costs from capital related costs.

Issue No. 4 -- Unused Space

The Board finds that the Provider's treatment of its unused space on its tenth floor as normal standby costs was reasonable and acceptable. 42 C.F.R. § 413.9 allows normal standby costs. It is noted that the Provider eventually used this space in later years.[10] The Board further finds that the Provider acted prudently in closing its tenth floor. It reduced operating costs and operated its overall facility in a very efficient manner. There was no delicensing of beds while the tenth floor remained unused. Furthermore, the beds on the tenth floor were maintained and available for use, if necessary. The Board concludes that the Provider's treatment of costs attributable to the unused tenth floor as normal standby costs was reasonable and prudent. The Intermediary's adjustment is reversed.

DECISION AND ORDER:

Issue No. 1 -- Cell Biology Costs and Revenues

Cell biology revenues should be removed from the oncology cost center revenues used in the Medicare cost apportionment. The Intermediary's adjustment is reversed.

Issue No. 2 -- Medicare Crossover Bad Debts

$117,140 of the $356,000 Medicare crossover bad debts are allowable. The Intermediary's adjustment is modified.

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[10] Tr. at 39.

Issue No. 3 -- Building Rental Costs

The rental costs claimed by the Provider are allowable capital-related costs. The Intermediary's adjustment is reversed.

Issue No . 4 -- Unused Space

The costs of the Provider's unused space on its tenth floor are normal standby costs. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: August 02, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman