PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D40

PROVIDER -
Northwood Nursing & Convalescent Home, Inc.
Philadelphia, PA

Provider No. 39-5863

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/Veritus Medicare Services

DATE OF HEARING-
December 19, 2001

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 96-2090R

INDEX

ISSUE:

Whether the Provider is entitled to reimbursement as ancillary services, certain nursing service costs for monitoring the functional operation of air-fluidized beds (AFBs) for the care of Medicare patients with stage IV pressure ulcers/decubitus ulcers?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Northwood Nursing and Convalescent Home (Provider) is a 148 bed skilled nursing facility (SNF), located in Southeast Pennsylvania. By letter dated October 31, 1995, the Intermediary forwarded to the Provider its Adjustment Report for calendar year 1993. It included Veritus Medicare Services' (Intermediary's) reclassification of nursing service costs claimed and reported by the Provider in the Clinitron therapy cost center to the Provider's routine nursing cost center. The costs reclassified by the Intermediary are for nursing services required to monitor the functional operation of AFBs for the treatment of patients with stage IV pressure ulcer/decubitus ulcers. The Provider originally reclassified $56,179 of nursing costs from routine costs to ancillary costs based on an hourly nursing rate of $16.47 times 3 hours per day times 1,137 days of providing AFB services. The Intermediary's adjustment resulted in a reduction in Medicare reimbursement of approximately $52,000.

The Provider furnished AFBs to its residents with stage IV pressure ulcers/decubitus ulcers. This consisted of a group of residents representing a small percentage of its total patient population. For 1993, the majority (approximately two-thirds) of the Provider's residents utilizing AFBs were Medicare beneficiaries. The Intermediary recognized the cost of leasing the AFBs as an ancillary cost. The nursing costs at issue are for non-routine functions for required monitoring by the Director of Nursing and the Charge Nurse for the functional operation of the fan/heater, consistency of sand/gel, air, alarm system, sanitization of the mattress, pad replacement and temperature control of the AFBs. These services and the nursing hours required to perform same were identified by the Provider's supplier of AFBs as both non-routine and essential to the effective use of the AFBs.[1] The Provider charged all payors for the cost of leasing AFBs. Its customary charges for them were provided to the Intermediary.

The Provider appealed the Intermediary adjustment to the Provider Reimbursement Review Board (Board). The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Jules S. Henshell, Esquire, of Wolf, Block, Schorr and Solis-Cohen, LLP. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly reclassified certain nursing service costs

[1] See Provider Exhibit 6.

for monitoring the functional operation of AFBs for the care of Medicare patients with stage IV pressure ulcers/decubitus ulcers from the Provider's ancillary cost center for "Clinitron Therapy" to routine nursing costs. Medicare regulations governing reimbursement for skilled nursing facilities define ancillary services as "services for which charges are customarily made in addition to routine services." 42 C.F.R. § 413.53(b). HCFA Pub. 15-1 § 2202.6 provides, in relevant part, that inpatient routine services in a skilled nursing facility "generally are those services included by the Provider in a daily service charge -- sometimes referred to as the "room and board" charge . . , included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made . . . ." (Emphasis added). The Provider Reimbursement Manual excludes from routine services in SNFs those services which meet the criteria for ancillary services. See HCFA Pub. 15-1 § 2203.1.

The Provider notes "ancillary services" are described in HCFA Pub 15-1 §§ 2202.8 and 2203.2. HCFA Pub. 15-1 § 2202.8 provides that ancillary services may include "special items and services for which charges are customarily made in addition to a routine service charge." Further, HCFA Pub. 15-1 § 2203.2 establishes the following criteria for ancillary services:

- Direct identifiable services to individual patients,
- Not generally furnished to most patients,
- One of the following:

  Not reusable, e.g., artificial limbs and organs, braces, intravenous fluids or solutions, oxygen (including medications), disposable catheters;

  Represent a cost for each preparation, e.g., catheters and related equipment, colostomy bags, drainage equipment, trays and tubing;

  Complex medical equipment, e.g., ventilators; or

  Support surfaces. The support surfaces which are classified as ancillary, are those listed under the Durable Medical Equipment Regional Carrier's (DMERC) level 2 and level 3 support surfaces categories. For example, support surfaces, which qualify under DMERC's level 2 support surface criteria are low air loss mattress replacement and

> overlay systems. An example of support surfaces which qualify under DMERC's level 3 support surface criteria is air fluidized therapy.

HCFA Pub. 15-1 § 2203.2.

Clearly, HCFA Pub. 15-1 § 2203.2 expressly allows those direct services, such as the non-routine nursing services required to monitor the functional operation of AFBs as ancillary services. Indeed, suppliers of AFBs advise providers of the non-routine nursing services required to monitor the effective use of this complex equipment.[2] The Provider's supplier of its AFBs informed it of both the routine and non-routine nursing services required and quantified the nursing time required for each.

The Provider notes that the nursing costs at issue meet the criteria for ancillary services. The Board has previously opined that a provider may properly create a separate cost center for AFBs and classify the costs associated with them as ancillary. See, Kent County Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Rhode Island, PRRB Dec. No. 95-D62, September 12, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,622 (Kent). In Kent, the intermediary argued that the leasing costs for AFBs were "routine" and argued that an ancillary cost center for AFBs was inappropriate because, among other things, it did not include nursing salaries which the intermediary asserted were a usual attribute of a cost center associated with an AFB. In the instant case, the Intermediary conceded the propriety of the Provider's classification of AFB leasing costs in its Clinitron bed cost center. In contrast to the intermediary in Kent, the Intermediary in this case contended that those specialized nursing costs for monitoring the functional operation of such AFBs were routine and not ancillary nursing costs. The Intermediary's only witness ultimately conceded that the ancillary nature of the specialized nursing services associated with the Clinitron beds was not an issue with him.[3]

The Provider observes that the specialized nursing services were clearly identifiable services to individual patients. The services included in the Clinitron bed cost center required monitoring by the Director of Nursing and Charge Nurse of the functional operation including the fan/heater, consistency of sand/gel, air, alarm system, sanitization of mattress routinely and as needed, pad replacement and temperature control.[4] The Provider witness' uncontroverted testimony was that AFB therapy was provided to a small percentage of the total patients of the Provider.[5] AFB

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2 See Provider Exhibit 3.

3 Transcript (Tr.) at 103.

4 Tr. at 33 and 34; See Provider Exhibit 3.

5 Tr. at 26.

therapy is not a routine item.[6] It must be and was ordered by a physician for each patient.[7]

The Provider states that its witness testified that each time a nurse has some type of involvement with a patient, that nurse has to note it on the patients' charts. The nurse actually came and provided the service and put it in the patient's medical record, and it was available for the Intermediary at the time.[8] He further testified that if the Intermediary reviewed the medical records of the patients provided with AFBs, those records would have substantiated the provision of the non-routine nursing services associated with use of AFBs to each AFB therapy patient. The undisputed testimony of record in this matter is that the Intermediary refused to engage in cost-finding to resolve any issue related to the documentation of the services. The Intermediary refused to come to the facility and refused to talk to the staff and to the supplier.[9] Moreover, prior to the audit, having accepted the Provider's reclassification of nursing costs for AFBs in the prior cost-reporting year, the Intermediary failed to advise the Provider of any deficiency in its record keeping.[10] Such failure on the part of the Intermediary contravenes its obligations to advise the Provider as to required record keeping. See HCFA Pub. 15-1 §§ 2404.1, 2404.2 and 2404.3. The Intermediary's witness agreed.[11] Indeed, upon cross-examination, the Intermediary's witness testified that he was not questioning that each AFB was necessary and approved, and that the provision of the claimed nursing services attendant to each AFB was not an issue.[12]

The Provider further contends that the Intermediary breached its duty to engage in cost finding and erroneously contended for the first time at hearing that the specialized nursing costs classified by the Provider to its Clinitron therapy cost center could not be recognized because the costs were estimated. Medicare is generally required to pay for services furnished by providers on the basis of reasonable cost, or the Provider's customary charges for those services, if lower. See 42 C.F.R. § 413.1(b). In determining the reasonable cost for covered services, Medicare expressly authorizes and contemplates "cost finding" to determine actual costs. See HCFA

Pub.15-1 § 2300, et seq. The Provider does not dispute that it must provide adequate cost data.

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6 Tr. at 24.

7 Id.

8 Tr. at 48.

9 Tr. at 44, 45 and 73.

10 Tr. at 43.

11 Tr. at 100 and 101.

12 Tr. at 96 and 97.

See 42 C.F.R. § 413.24. However, adequate cost data is properly the subject of cost finding. Cost finding is defined by Medicare as "a determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continuous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs." See HCFA Pub. 15-1 § 2302.7. Further, the Medicare Program expressly authorizes the Intermediary to find costs by reviewing "other records and documents," including "studies." See HCFA Pub. 15-1 § 2404.2. Nowhere does the Medicare Program exclude the use of studies or documents such as those identified and relied upon by the Provider. These included supplier information, consistent time studies by other skilled nursing care providers, and Director of Nursing documented observations based on actual experience of the Provider's Administrator/Director of Nursing who provided the service. The Medicare Program does not limit the use of studies to those performed by the Provider. It employs the use of studies to determine and establish a reasonable cost basis for reimbursing providers. See HCFA Pub. 15-1 §§ 1306.A and 1306.B. The testimony at the hearing established that the time studies relied upon by the Provider were consistent with common practice in the industry and accepted by other Medicare Intermediaries.[13] Indeed, the Intermediary had previously accepted such cost reporting and cost finding by the Provider in the immediately preceding fiscal year.

Notwithstanding the foregoing examples of the Medicare Program's anticipation and acceptance of cost finding on the basis of informal procedures and documentation and studies other than contemporaneous recording of time spent per task by each staff person, the Provider notes that the Intermediary nevertheless contends that nothing short of contemporaneous records of the amount of time to perform each AFB monitoring service by nursing would satisfy it.[14] This was contrary to the position of the Intermediary prior to hearing. After audit and prior to this appeal, the Provider supplied the Intermediary with the only documentation it suggested it required -- "something from the supplier."[15] The Intermediary, however, refused to verify or consider it.[16] Nor would the Intermediary review or consider the approval of such costs for inclusion in a separate ancillary cost center at audit by other intermediaries both outside and in Pennsylvania.[17] Indeed, the Intermediary refused to consider its own actions of accepting the inclusion of nursing costs in Provider's Clinitron bed cost center in the prior year or accepting such inclusion by another provider.[18]

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[13] Tr. at 47 and 62

[14] Tr. at 91, 103 and 104.

[15] Tr. at 73; Provider Exhibit 6.

[16] Tr. at 73.

[17] Tr. at 47 and 73.

[18] Tr. at 47 and 62.

The Provider notes that it was not until the hearing, upon interrogation by the Board, that the Intermediary stated that corroboration of time required for non-routine nursing services might be reasonable if from multiple equipment manufacturers.[19] Indeed, the time for the Intermediary to ask for corroboration by seven AFB manufacturers is not at a hearing. The Intermediary's identification of this issue at hearing is both untimely and contrary to its obligations, pursuant to HCFA Pub. 15-1 §§ 2404.1, 2404.2 and 2404.3, to advise a provider of documentation required to support costs. As set forth above, applicable Medicare regulations and guidelines do not require that standard demanded by the Intermediary to verify the ancillary nursing costs at issue. The Provider submits that the information supplied and offered to the Intermediary is sufficient to meet the cost finding requirements of applicable Medicare law and regulation to support reimbursement for the nursing services which the Intermediary ultimately conceded at hearing constitute ancillary services. Accordingly, the Intermediary's contention in this matter that its reclassification of nursing costs allocated to Provider's Clinitron bed therapy cost center was proper because the costs were not the product of contemporaneous time records recording the actual time spent on each task by each nurse is erroneous and improper because it is not consistent with and exceeds the cost finding requirements of the Medicare Program. Further, the Intermediary's analysis did not include any explanation why, if documentation was insufficient for such costs in Provider's ancillary cost center, they were allowed and reallocated to another cost center rather than disallowed. Cost finding for ancillary services under the Medicare Program is no more stringent than cost finding for allowable routine services. Moreover, the Intermediary relied upon HCFA Pub. 15-1 § 1310 (sic) as authority for its reclassification. That section simply bears no relation to the time documentation argument proffered by the Intermediary. Finally, the Provider's records of customary charges to non-Medicare residents for these services were provided to the Intermediary, further enabling the Intermediary to verify a reasonable cost to the Program pursuant to 42 C.F.R. § 413.1.[20]

The Provider further notes that by reclassifying the nursing services at issue from the Provider's ancillary cost center for Clinitron bed therapy to routine nursing, the Intermediary violated the Medicare Program objective that costs with respect to individuals covered by the Program shall not be borne by individuals not so covered. As set forth above, the Provider's witness testified that while there were a small number of patients who required and received AFB therapy, approximately two-thirds of those patients were Medicare patients.[21] The reimbursement impact of the Intermediary's reclassification of the nursing services at issue was that 67% of this nursing cost for Medicare patients has not been reimbursed.[22] In contrast, the Provider's non-Medicare patients received an additional, separate charge for the three hours per day of ancillary nursing

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[19] Tr. at 106.

[20] Tr. at 68 and 69.

[21] Tr. at 26 and 51.

[22] Tr. at 51.

services associated with their AFB therapy.[23] It follows that the Intermediary's reclassification of the cost of admittedly ancillary nursing services associated with AFB therapy to routine nursing costs serves to shift the burden for those costs from the Medicare Program to non-covered individuals. Such result violates the Medicare Program objective set forth at 42 C.F.R. § 413.9(b), which clearly and unambiguously states that ". . . [t]he costs with respect to individuals covered by the [Medicare] Program will not be borne by individuals not so covered[,] . . ." It also violates the principle that total allowable costs of a provider will be apportioned equitably between program beneficiaries and other patients so that the share borne by the Medicare Program is based upon actual services received by program beneficiaries. The Intermediary did not dispute that the non-routine nursing services at issue were medically necessary and received by Medicare patients.[24]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the Provider's reclassification of nursing costs to the ancillary cost center does not meet the requirements of HCFA Pub. 15-1 § 2203.2. Ancillary services are defined as items or services for which there is a separate charge, and for which there is a direct identifiable service to an individual patient. In this case, the Provider could not match a directly identifiable service to an individual patient. The Provider did not maintain a separate nursing staff to perform services related to the use of AFBs. Further, the Provider did not capture the costs of those nursing services in its trial balance. The nursing services were performed as a part of routine nursing. The Provider made an after-the-fact reclassification based on estimates of time needed to monitor and treat patients in AFBs.

The Intermediary observes that the Provider's reclassification of nursing hours was based on an estimate of necessary nursing services provided by a vendor of AFB beds, not necessarily the manufacturer of the beds used by the Provider. In addition, the Provider's administrator provided a memorandum, which mirrored the language in the manufacturer's time estimate. The Intermediary argues that none of these estimates are acceptable because the Medicare Program reimburses actual cost, not estimates of cost.[25]

The Intermediary notes that routine nursing care covers all of the services involved when a nurse monitors and treats a patient in a routine bed. There is no evidence in the record that supports an

argument that any nurse was providing services that were not part of the routine nursing service. While the manufacturer indicated that services such as monitoring the fan/heater or alarm system are necessary,[26] there is no evidence that such services were ever performed, or for which

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23 Tr. at 67 and 69.

24 Tr. at 96 and 97.

25 Tr. at 83.

26 See Provider Exhibit 6.

patients such services may have been performed.[27] A nurse walking into a patient's room would normally monitor any item or service that patient is receiving. The mere monitoring of a patient's condition is routine nursing. In order to support an ancillary service, the Provider must show that a specific item or service was provided to a specific patient, and that a charge was levied for that item or service. In this case, the Provider wants the Board to accept the idea that some service had to have been supplied by the routine nursing staff simply because the patient was in the AFB, and that the unidentified service amounted to three hours of specialized nursing service.

The Intermediary contends that the Board cannot determine whether any ancillary services were provided to patients in AFBs because there is no record that any such services were actually provided. Further, the Provider's records did not accurately substantiate the actual cost of nursing services provided to patients in AFBs or demonstrate that such services were different from services provided to any patient in a routine area of the facility. In order to demonstrate that the claimed nursing costs were for ancillary services, the Provider must be able to segregate actual time spent by nursing staff on ancillary services, along with a description of what the services consisted of. The Provider did not meet the requirements of determining the costs of AFB nursing costs. Without such a showing, the Board must conclude that the service is not a separate service, but a part of routine services provided to patients as part of a room and board charge.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.1(b)	-	Reasonable Cost Reimbursement
§ 413.9(b)	-	Definitions
§ 413.24	-	Adequate Cost Data to Cost Finding
§ 413.53 (b)	-	Definitions

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

§ 1306 et seq.	-	Application of Inpatient Routine Nursing Salary Cost Differential Adjustment Factor

[27] Tr. at 87.

§ 2202.6	-	Routine Services
§ 2202.8	-	Ancillary Services
§ 2203.1	-	Routine Services in SNFs
§ 2203.2	-	Ancillary Services in SNFs
§ 2300 et seq.	-	Adequate Cost Data and Cost Finding
§ 2302.7	-	Cost Finding
§ 2404 et seq.	-	Payments To Providers

3. Cases:

Kent County Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Rhode Island, PRRB Dec. No. 95-D62, September 12, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,622.

FINDINGS OF FACT,CONCLUSION 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 that the Intermediary properly reclassified the Provider's nursing costs for operating the AFBs from claimed ancillary costs to general routine care costs. The Board finds that the Provider properly set up a separate ancillary cost center to include costs related to the AFBs. The Provider properly included the rental costs of equipment in that cost center. The Board finds that specialized labor costs would have been allowed as ancillary costs if adequate documentation to support such a claim had been provided to the Intermediary and the Board. Unfortunately for the Provider, such documentation was not provided. The only significant evidence in the record was the testimony of the Provider's witness and after-the-fact information and opinion. The Provider alleged that medical records were noted when AFB services were rendered to patients. However, it failed to present even a sampling of its medical records to the fiscal Intermediary or the Board. Further, there were no time studies provided to support the amount of time spent providing specialized AFB services even though the Provider contented that such time studies had been developed by

other providers.

The Board finds that the Provider did present a manufacturer's estimated period of time (hours) for providing AFB services. The Board finds one manufacture's estimate insufficient to result in a reclassification of labor costs to the ancillary cost center. That standard may not be appropriate

for all providers or even this Provider. In actuality, it could have taken any number of hours, more or less than the three estimated by the manufacturer, to perform such services. The Board believes that additional documentation in the form of other manufacturer's specifications or estimates would have more adequately supported the Provider's position. In addition, affidavits from other providers would have given greater credence to the Provider's commentary that other providers had information about the amount of time required to provide specialized AFB services. In the final analysis, the burden of proof to support a claimed cost under Medicare rests with a provider. In this case, the Board concludes that such burden was not met.

DECISION AND ORDER:

The Intermediary properly reclassified nursing costs included in the AFB ancillary cost center back to the routine care cost center. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING

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

Date of Decision: September 18, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman