PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D8

PROVIDER – Blue Ridge Rehabilitation Center Martinsville, VA	**DATE OF HEARING-** January 30, 2002
Provider No. 49-5281	Cost Reporting Period Ended December 31, 1998
vs.	
INTERMEDIARY – Mutual of Omaha Insurance Company	**CASE NO.** 00-3980

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ISSUE:

Was the Intermediary's adjustment disallowing the allocation of general service costs to the ancillary cost centers proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Blue Ridge Rehabilitation Center is a 300 bed nursing home located in Martinsville, Virginia ("Provider"). The Provider is managed by Liberty Healthcare Management Corporation, located in Naples, Florida. Mutual of Omaha ("Intermediary") desk reviewed the Provider's cost report for the period ended December 31, 1998 and submitted an adjustment Report that included eliminating certain statistics from Worksheet B-1 relative to the allocation of indirect costs to certain ancillary departments. The Intermediary issued a Notice of Amount of Program Reimbursement (NPR) on August 23, 2000.

The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") on September 19, 2000 and has met the jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by John Todd of JCT Consulting, Inc. The Intermediary was represented by Thomas Bruce, Esquire, of the Mutual of Omaha Insurance Company. The amount of reimbursement in dispute is approximately $20,359.

PROVIDER'S CONTENTIONS

The Provider asserts that its position is more accurately framed by stating the issue as follows:

Did the Intermediary properly adjust the Provider's allocation of general service costs to the ancillary cost centers based on the lack of a clear and complete explanation as to the cause and reason for the disallowances and the Intermediary's inappropriate authority citation for the adjustment?

The Provider contends that both CMS Pub. 15-1 § 2306 and the regulation at 42 C.F.R. § 413.24 address the allocation of costs from general services (nonrevenue-producing) cost centers to other general service cost centers and to ancillary (revenue-producing) cost centers, but neither prohibit the allocation of such costs. 42 C.F.R. §413.24 states in part "All costs of nonrevenue-producing centers are allocated to all centers which they serve . . .," and CMS Pub. 15-1 § 2306 describes the potentiality of such allocation and supports the allocation of the indirect costs as necessary to ensure full determinations for the purpose of the proper matching of expenses to support revenue. Section 2306 states "Every nonrevenue-producing cost center has the potential of being allocated to every other nonrevenue-producing cost center in addition to revenue-producing cost centers."

The Provider contends that the Medicare regulation at 42 C.F.R. § 413.24 mandates that the step-down method is the required cost finding method for Skilled Nursing Facilities. This method utilizes apportionment of costs from nonrevenue-producing (general service) cost centers to other nonrevenue-producing cost centers and to revenue-producing (direct care and ancillary) cost centers for determining the full and reasonable costs of services provided. 42 C.F.R. 413.24d(1) states:

> Step-down Method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue -producing centers. All costs of nonrevenue-producing centers are allocated to all centers they serve, regardless of whether or not these centers produce revenue.

The Provider points out that the program instructions at CMS Pub. 15-1 § 2306 expand on the regulation as follows:

> . . . for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each revenue-producing center (indirect costs) based on the amount of services received.

The Provider also maintains that the allocation of general service costs to other departments, including ancillary departments, is further supported by the provisions that providers are to be paid their reasonable costs for services provided, as set forth in 42 C.F.R. §413.9, which states in part:

> (a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services.

and continues in identifying reasonable cost:

> (b) Definitions- (1) Reasonable cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services.
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> (c)(3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services . . . It includes both direct and indirect costs.

Id.

The Provider contends that the Intermediary did not provide an explanation or appropriate reference for any of the adjustments at issue. The Intermediary's narratives consisted of either "to remove (identified cost centers) overhead from the ancillary centers" or "to be consistent with prior year." These are statements of intent and not explanations of justifiable causes or reasons for implementing the adjustments.[1]

The Provider argues that the services provided to the ancillary departments by the affected general service departments are services related to the departments providing the services that are beneficial to the receiving departments, i.e., services in-kind. A description of some of the services provided by the Nursing Administration and the Social Services department can be found in correspondence to the Intermediary.[2]

The Provider points out that the Intermediary stated in other documentation that with respect to the Nursing Administration department, the services provided to ancillary departments, such as observation and chart review, were "incidental at best and are commonly identified as normal routine nursing care." The Provider argues that the services provided by the Housekeeping department, such as cleaning a toilet or mopping a floor, are as well incidental and commonly identified as routine housekeeping. Yet the Intermediary allows such allocation without objection and recognizes such as a "service-in-kind."

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1 Tr at 18-19, 28-29.

2 Tr at 33-34, 87-93, 108-112, 114-116

The Provider argues that it could be interpreted that because the general service department did not engage directly in the provision of the rehabilitation therapies, the allocation of the department's cost was inappropriate and not justified. CMS Pub. 15-1 does not state, nor do the regulations, that the service must be directly related to the services provided by the other department, but implies that the service relates to the services provided by the general service department, i.e., services-in-kind, such as laundry or housekeeping services.

The Provider points out that the Board affirmed the allocation of costs for the provision of services-in-kind from general service areas to the ancillary departments in Saint Mary's Hospital, Reno, Nevada v. Aetna Life Insurance Company, PRRB Dec. No 91-D32, April 2, 1991, ("CCH") Medicare and Medicaid Guide ¶ 39,155. In that decision the Board found "the costs of the Provider's Medical Records department should be allocated to all inpatient routine and ancillary service departments . . ." The Board based these findings on a determination that the ancillary departments receive services from the Medical Records department along with the routine departments. The Board also cited 42 C.F.R. § 405.453(d)(1)), (redesignated as 42 C.F.R. § 413.24(d)(1), in its definition of the step-down method of cost finding, which, "provides that all costs of nonrevenue-producing centers are allocated to all centers which they service, regardless of whether or not these centers produce revenue."

While Medical Records cost is not one of the cost allocations that is at issue in this dispute, the parallels are evident and consequential in the Board's description of its findings for the basis of its decision and in its considerations relative to this appeal. The Board's decision implies that the Medical Records department provides services related to medical records, and are, in essence, "services-in-kind" offered by a general service department.

The Provider points out that in another decision related to the allocation of costs from a general service cost center to ancillary cost centers, and this time with specificity to the Nursing Administration department, the Board substantiated the incidence of the allocation of indirect costs as being typical and routine. In Sharp Memorial Hospital, San Diego, California v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 92-D27, Jan. 21, 1992, Medicare and Medicaid Guide ("CCH") ¶ 40,172, the Board found that the costs of the general service (non-revenue producing) centers being allocated to ancillary (revenue-producing) departments was justifiable and allowable. The Decision was based on the provider's reclassification of costs for salaries and benefits for nursing supervisors from the routine services area to the Nursing Administration cost center and the intermediary's adjustment reclassifying the costs back to the routine services area. A significant parallel is clearly implicit in the Board's reasoning.

In the Sharp Memorial Hospital decision upholding the intermediary's adjustment of the reclassification of nursing supervisors' salaries and benefits back to the routine services area from the Nursing Administration cost center, the Board stated: "Reclassifying the supervisors' hours from routine areas to nursing administration would result in those costs being allocated to ancillary departments . . ." The Provider argues that this clearly implies and affirms a justification for, and the acceptability of, the allocation of costs from the Nursing Administration cost center to ancillary departments.

The Provider contends that in Sharp, the Board suggested in its reasoning that the provider had allocated nursing administration cost to the ancillary departments, and the Intermediary apparently determined that such allocations were justified and acceptable. This conjecture is supported by the failure of the Intermediary to make adjustments to reverse the "suggested" cost allocations of Nursing Administration costs to the ancillary departments. The Provider argues that the parallels are evident. The Nursing Administration department is a general service department providing services to other departments, including ancillary departments, and the allocation for these indirect costs is justifiable and allowable.

The Provider contends that the Intermediary made an uninformed and random assumption when it adjusted the allocated Central Supply costs to the Inhalation Therapy Department. The Intermediary's reason for the adjustment was that "the sampled invoices for a provider in the chain showed that the contracted company provides its own supplies." The implication is that the respiratory therapy supplier contracted with the other provider in the chain and also contracted with the instant Provider.

The Provider contends that it has contracted with the Inhalation Therapy department of a local hospital, which is not under contract with any related provider. Had the Intermediary reviewed W/S's A-8-4 and A-8-5 for Respiratory Therapy, it would have noted that there are no cost entries for supplies on Lines 43 and 62 of the respective W/S's.

The Respiratory Therapy department obtains routine medical, nursing and pharmaceutical supplies from the Provider's Central Supply and Pharmacy departments. These include routine supplies such as gloves and oxygen tubing from the Central Supply cost center and sterile water and lubricants from the Pharmacy cost center.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not demonstrated that there were any services provided to the ancillary cost centers by either the Nursing Administration department or the Social Services department. Even if they could, for argumentative purposes, it can not be quantified in such a way as to allocate these costs down to the ancillary cost centers. Therefore, the statistical bases claimed by the Provider results in a miscalculation of costs.

The Intermediary maintains that the Medicare regulations at 42 C.F.R. § 413.20 require: ". . . that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program . . . . "and that they must be " . . . capable of verification by a qualified auditor . . . ." The regulations at 42 C.F.R. § 413.24 describe the cost finding methodology, including the step-down method of allocating non-revenue generating cost centers to all cost centers they serve. Cost report instructions provide the recommended and acceptable statistics for implementation of the step-down methodology.[3] The Provider's allocation did not adhere to the aforementioned regulations and/or Program policy by failing to adequately document the services rendered and by failing to meet the criteria required of periodic time studies.

The Intermediary asserts that the Provider's time studies do not meet the Program requirements in that the time studies in question covered just one week per quarter. According to CMS Pub. 15-1 § 2313.2E ". . . A minimally acceptable time study must encompass at least one full week per month of the cost reporting period . . . ." Moreover, the time studies were not signed and/or dated. In some instances, the time studies were clearly filled out by the same person (similar handwriting) even though they pertained to different individuals. The Intermediary does not believe the individuals to whom the time studies relate actually completed the time studies. There is no narrative backup for the time studies and little, if any, description as to what was happening. The Intermediary was unable to relate the total of the statistics on the time studies for the four quarters to the statistics used on the cost report. Therefore, the time studies were not auditable documentation.

The Intermediary argues that the Provider's presentation in its supplemental position paper as well as at the hearing was an attempt to shift the burden of proof to the Intermediary through exhaustive scrutiny of the Intermediary's narrative explanations in its adjustments and policy citations, alleging that the explanations were inadequate and the citations were improper. The

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3 CMS Pub. 15-1 § 2313

Intermediary was questioning what services, if any, were actually provided to the ancillary departments through conversations with the auditor.[4]

The Intermediary points out that at the hearing the Provider's representative stated ". . . this accumulation of time comes from daily time sheets, which were . . . maintained, but they've since been lost."[5] The Intermediary argues that those disclosures solidify its argument that the time studies were not reliable documentation.

The Intermediary points out that the Provider's witness, when asked what she would call services in kind responded: ". . . a support service most for coordination or a liaison role . . . ."[6] Also, the witness, when asked by the Intermediary whether benefits are flowing back from the ancillary areas, testified "that's entirely true "[7] thus, confirming the fact that it is a two-way street when it comes to benefits flowing back and forth between departments in the nursing home. Furthermore, the witness, when asked by the Intermediary if she observed the completion of the time studies and/or got involved with them at all, replied ". . .not routinely . . . ."[8] Therefore, the Intermediary argues that the testimony offered by the witness weakened the Provider's argument that the so-called services moved only in one direction, i.e., to the ancillary cost centers. In addition, the witness could not truly attest to the authenticity of the time studies.

The Intermediary comments that the activity taking place between the general service cost centers and the ancillary cost centers was, in reality, the coordination of the care plan to be given to the residents, not a support service as implied by the Provider. As a result, the allocation of general service costs to the ancillary cost centers was not warranted.

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 Report

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4 Tr at 33.
5 Tr at 94-96
6 Tr at 95-96.
7 Tr at 114.
8 Tr at 118.

§ 413.24 et seq - Adequate Cost Data and Cost Finding

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

§ 2306 - Cost Finding Methods

§ 2313 et seq. - Changing Bases for Allocating Cost Centers or Order in Which Cost Centers are Allocated

3. Case Law

Saint Mary's Hospital, Reno, Nevada v. Aetna Life Insurance Company, PRRB Dec. No. 91-D32, April 2, 1991, Medicare and Medicaid Guide ("CCH") ¶ 39,155.

Sharp Memorial Hospital, San Diego, California v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 92-D27, January 21, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,172.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, testimony at the hearing and evidence presented, finds and concludes that the Intermediary properly adjusted the Provider's general service costs.

We reject the Providers position that it is entitled to payment if the Intermediary failed to state adequate reasons or proper citations of authority for the adjustments. Without deciding whether the Intermediary's rationale was sufficiently stated, the Board has authority to reverse adjustments only where a provider demonstrates entitlement to Medicare payment, not as a sanction against the Intermediary.

The Board finds that the Provider did not present adequate documentation to properly allocate the Nursing Administration and Social Services costs to the ancillary cost centers. The Medicare regulation at 42 C.F.R. § 413.20 requires: ". . .that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the Program . . . . " and that they must be " . . . . capable of verification by a qualified auditor . . . ." The Medicare regulation 42 C.F.R. § 413.24 describes the cost finding methodology, including the step-down method of allocating non-revenue generating cost centers to all cost centers they serve. The cost report instructions at CMS Pub. 15-1 § 2313 also provide the recommended and acceptable statistics for implementation of the step-down methodolgy. The Board finds that the Provider's allocation did not adhere to the aforementioned regulations and program policy in that they fail to adequately document the services rendered and failed to meet the criteria required for periodic time studies.

The Provider submitted time studies for only one week per quarter. According to CMS Pub. 15-1 § 2313.2E ". . . A minimally acceptable time study must encompass at least one full week per month of the cost reporting period . . . ." The Board also finds that the time studies were not signed or dated. In some instances the time studies appear to have been completed by the same person even though they pertained to different individuals. Testimony at the hearing revealed that the back-up for the time studies was lost or misplaced and not available for the Intermediary's audit.

The Board finds that the testimony of the Provider's witness was credible that the Nursing Administration and Social Services departments played an important role in the facility. Position descriptions submitted by the Provider also appear to require interaction by the Nursing Administration and Social Services personnel with ancillary departments. However, the time studies do not authenticate the time spent or that the job functions were actually carried out. The Board also finds that the individual timesheets do not add up to the total time claimed by the provider. The Provider was given ample opportunity to submit additional documentation but did not do so. The Board finds the two cases cited by the Provider to supprt its position, St. Mary's Hospital and Sharp Memorial, are not on point and disregard them in its decision.

DECISION AND ORDER

The Intermediary's adjustment reclassifying the Nursing Administration and Social Services cost centers was proper. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTCIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S

DATE OF DECISION: December 19, 2002

FOR THE BOARD:

Suzanne Cochran
Chairperson