PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D68

PROVIDER –
The Manor House at Riverview
Noblesville, Indiana

Provider No.: 15-5281

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
AdminaStar Federal-Indiana

DATE OF HEARING –
June 23, 2005

Cost Reporting Period Ended -
December 31, 1996

CASE No.: 99-2385

INDEX

ISSUES**:**

1. Whether the Intermediary's adjustment of the square footage statistic for the Physical Therapy department was proper.

2. Whether the Intermediary's adjustment disallowing owners' compensation was proper.

3. Whether the Intermediary's denial of the Routine Cost Limit exception request due to the Provider's failure to respond to a documentation request timely was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare Program reimburses providers for the reasonable costs they incur to furnish physical and other therapy services to Medicare beneficiaries. 42 U.S.C §1395x(v)(1)(A) provides, in part, that the reasonable cost of any service shall be the actual cost incurred, excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The statute also authorizes the Secretary to establish cost limits. Essentially, the limits recognize reasonable costs based upon estimates of costs found to be necessary in the efficient delivery of covered items and services.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Manor House at Riverview (Provider) is a freestanding Skilled Nursing Facility located in Noblesville, Indiana. AdminaStar Federal (Intermediary) reviewed the cost report for the Fiscal Year Ending (FYE) 12/31/96 and made adjustments to the cost report. The Provider disagrees with the Intermediary's handling of two issues which were adjusted on the cost report. The

Provider also disagrees with the Intermediary's denial of its request for an exception to the Routine Cost Limit (RCL).

Issue #1: Square Footage Statistic for Physical Therapy

The Provider is located on the fourth floor of Riverview Hospital, a separate and unrelated entity, and leases the space it occupies from the hospital. Square footage was utilized by the Provider as the allocation basis for its Physical Therapy cost center, and the Provider claimed 725 square feet for this cost center on its "as-filed" cost report for the year at issue. The square footage statistic was calculated as a percentage of the total physical therapy area of Riverview Hospital and was based on the number of beds operated by the Provider relative to the total number of beds operated by both Riverview Hospital and the Provider.

The Intermediary determined from the Provider's floor plan that the Provider had a 408 square foot room in its leased premises for physical and occupational therapies. Since both occupational and physical therapies were provided in this room, the Intermediary divided the square footage between the two cost centers and allocated one-half of the total (204 square feet) to each of the cost centers. No other space on the floor plan was designated for physical therapy, and the Provider did not appeal the Intermediary's adjustment to the square footage statistic for the Occupational Therapy cost center (which on the as-filed cost report was reported as zero).

The reduction of square footage for the physical therapy department resulted in a reduction of $12,600 in the Provider's Medicare reimbursement for fiscal 1996.

Issue #2: Owners' Compensation

The Provider's ownership is divided among three individuals, each of whom maintains other business interests that are unrelated to the Provider's operations. For fiscal year 1996, the Provider paid a total of $39,600 to the owners; $36,000 was classified as management fees and $3,600 was classified as directors' fees. The Intermediary performed a desk review of the FY 1996 cost report. Based on the documentation submitted with the cost report, including the size of the facility and the reported duties of each owner, the Intermediary determined that neither direct nor indirect patient care responsibilities were substantiated outside of monthly board meetings attended by the owners. The Intermediary, therefore, allowed $200 of compensation, per board member, per meeting. The total allowed was $7,200 (3 members x 12 meetings x $200). The remaining $32,400 of the owners' compensation claimed was determined by the Intermediary to be excess compensation and was disallowed.

The adjustment to remove the majority of owners' compensation resulted in a reduction of Medicare reimbursement of $15,500.

Issue #3: Denial of RCL Exception

Upon the settlement of the cost report, the Provider submitted a request to the Intermediary for an exception to the RCL for FYE 12/31/96. The request was dated March 8, 1999 and was submitted timely (within the 180-day timeframe from the date of the Notice of Program

Reimbursement (NPR) which was issued on September 30, 1998). The Intermediary, upon review of the exception request, determined that the request was inadequate and prepared a letter dated May 25, 1999 denying the first request and requesting the Provider resubmit the request with the appropriate documentation within 45 days of the date of the letter.

Upon the Provider's failure to respond to the Intermediary's request for additional documentation by the 45th day, the Intermediary notified the Provider in a letter dated July 14, 1999 that the exception was officially denied. Upon receipt of the July 14, 1999 letter, the Provider contacted the Intermediary to follow up on the denial and informed the Intermediary that it did not receive the May 25, 1999 letter and was unaware of the 45-day timeframe established in that letter. The Intermediary did not have proof of delivery but forwarded a copy of the letter to the Provider for informational purposes only. The Provider then submitted a request to the Intermediary on July 19, 1999 to resolve this issue but received no response.

The Medicare reimbursement impact of the denied exception to the RCL is approximately $215,100.

The Provider appealed the two audit adjustments and the final determination of the RCL exception request to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835-405.1841. The Provider was represented by Joseph R. Clausman, Jr. of Clausman & Associates, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue #1: Square Footage Statistic for Physical Therapy

The Provider contends that the square footage reported on the as-filed cost report for the physical therapy cost center was representative of a portion of the total square footage of Riverview Hospital's Physical Therapy Department. The Provider's position paper indicates that the allocation was based on the ratio of the number of Provider beds divided by the total of Riverview Hospital and Provider Beds. The Provider's position paper also states that the lease agreement and services agreement between the Provider and the Hospital indicate "Riverview hospital was to permit the Provider access to its therapy areas to provide efficient utilization of resources by both Parties."[1]

The Intermediary asserts that the adjustment to square footage was made based on auditable documentation submitted by the Provider, which was the Provider's floor plan with square footage reported for each room and each room labeled with its function. Additionally, the Intermediary asserts that it cannot locate in the provided lease or purchased services agreements where the agreements state that the Provider will have access to the Riverview Physical Therapy Department. The language found in the purchased services agreement indicates that "Riverview shall have control over all stages in the preparation of the services and in the provision of the services to the extent that they are prepared or provided on Riverview's premises and not on the

[1] Page 3, Provider's Revised Position Paper and Provider Exhibits P-3 and P-4.

leased premises."[2] In addition, the agreement states in Attachment A, "Services may be rendered by the employee, agent or representative of Riverview at the Leased Premises or on Riverview's premises."[3] The Intermediary asserts that the Provider is merely purchasing the physical therapy services from the hospital, and these services and square footage should be handled no differently than other purchased services that are rendered on the supplier's premises.

Issue #2: Owners' Compensation

The Provider asserts that the management fees and directors' fees paid to the facilitys' owners are allowable costs. The Provider contends that the owners provide necessary functions for the provider such as the purchase/negotiation of group health insurance rates for this provider and the other providers owned by the ownership group. In addition, the Provider argues that since one owner, Mr. Spaugh, signs the cost reports and assumes legal liability for the information included in those reports, he must be intricately involved with the management of the facility. The Provider further claims that the duties performed by the owners of this facility are akin to those of regional administrators or consultants utilized in chain organizations.

The Intermediary asserts that the three owners respectively reported spending an average of seven hours, four hours and zero hours weekly providing services at the Provider. For the reported hours worked per week, each owner was paid $13,200. The duties performed by the two owners who do claim to spend time at the facility were not fully detailed, and as the facility employs a full-time administrator, business manager, bookkeeper, Director of Nursing and three additional office personnel, the necessity of the owners' functions was questioned.

The owners indicated that they had each attended twelve board meetings during the prior fiscal year, and the Intermediary assumed that each owner had also attended twelve board meetings for the current year. The Intermediary allowed $200 in compensation for each board meeting attended by each owner during fiscal year 1996 (total of $7,200) but disallowed the remaining compensation ($32,400), contending that the Provider failed to substantiate that any of the services provided by any of the three owners "were rendered in connection with direct or indirect patient care rather than for the primary purpose of managing or improving their financial investment."[4]

Issue #3: Denial of RCL Exception

The Provider contends that its request for an exception to the RCL was filed timely on March 8, 1999, that it never received the Intermediary's denial and request for resubmission letter of May 25, 1999, and that the Intermediary cannot provide proof of delivery of the letter. The Provider, therefore, contends that the denial was erroneous and the Intermediary should review the Provider's request for an exception to the RCL.

The Intermediary indicates that its response to the initial RCL exception request and its denial letter were in accordance with 42 C.F.R. §413.30(c)(2). The Intermediary asserts that the denial

[2] Page 2 of Provider Exhibit 4.
[3] Page 6 of Provider Exhibit 4.
[4] Intermediary's position paper, page 20.

letter was sent on May 25, 1999, 78 days after the receipt of the Provider's RCL exception request, which meets the 90-day requirement. The Intermediary claims that it appropriately issued a final determination denial when the information it had requested was not received within 45 days from the May 25, 1999 letter.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence presented and the arguments of the parties, finds as follows:

Square Footage

The Board, after careful consideration of the material presented, cannot locate any evidence that the Provider was given access to any portion of Riverview Hospital's physical therapy department. The Board finds that the services agreement between the Provider and Riverview Hospital [5] indicates that Riverview Hospital was paid for physical therapy services rendered to the Provider's patients, regardless of whether the services were performed on hospital premises or on the provider's leased floor. The payments made to Riverview Hospital for services provided would therefore cover all costs, including the space costs incurred if treating patients on hospital premises. The Board therefore finds that the Intermediary's adjustment limiting physical therapy square footage to half of the square footage identified as OT/PT was a more reasonable approach in determining square footage for Provider's physical therapy cost center.

Owners' Compensation

The dispute over the amounts claimed for owners' compensation centers on the nature of and need for the services provided by the owners. The controlling regulation for owners' compensation, 42 C.F.R. §413.102(a), recognizes compensation of owners as an allowable expense provided the services are actually performed in a necessary function. In addition, 42 C.F.R §413.102(b)(3)(i) requires that, for a service to be necessary, the institution would have had to employ another individual to perform it had the owner not done so.

The Provider argued that the services provided by the owners were necessary to the operation of the facility. The Provider, however, did not supply auditable documentation to support its contention. On the contrary, the documentation submitted supports the Intermediary's contention that the owners did not perform necessary functions, as one owner documented no time spent on activities at the facility, and the other two owners had limited hours with no specific job functions.[6] The Board concludes that the Intermediary properly adjusted the amounts claimed by the Provider for the owners' involvement in the operation of the facility.

RCL Exception Denial

It is undisputed that the Provider initially filed a timely RCL exception request within 180 days of the issuance of the NPR. What is in dispute is whether the Provider's failure to receive the

[5] Provider's Position Paper, Exhibit P-4, pages 7-8
[6] Intermediary Exhibit I-2.

Intermediary's initial denial letter for that request and the consequent failure to then submit a new request timely enables the Intermediary to issue a final denial without review of the Provider's documentation. The controlling manual provision implementing the final denial of a RCL exception if documentation is not submitted within 45 days of the initial denial letter is CMS Pub 15-1 §2531.1.

The Provider claims it did not receive the Intermediary's denial letter dated May 25, 1999, and the Intermediary is unable to provide proof of delivery for that letter. This places the Provider in the position of having to prove a negative. It is not implausible that letters are lost in the mail, misplaced prior to sending or simply not sent. Under the circumstances, where the Provider's exception request would be officially denied after "45 days from the date of the intermediary's denial"[7], the Intermediary should have proof of delivery or proof of mailing. As proof of mailing is generally identified as the postmark, and the postmark cannot be identified in instances where a letter was lost or never received, it would not be unreasonable to require that the Intermediary supply proof of delivery[8]. This burden of proof is no different than the timeliness burden of proof a provider must meet when submitting cost reports, hearing requests, etc.

The Board concludes that the Provider was unable to respond to the Intermediary's letter requesting additional documentation as it was not received; therefore, the Intermediary improperly denied the RCL exception request.

DECISION AND ORDER:

Square Footage:

The Intermediary properly adjusted the physical therapy square footage. The Intermediary's adjustment is affirmed.

Owners' Compensation:

The Intermediary properly disallowed a portion of the Provider's owners' compensation costs. The Intermediary's adjustment is affirmed.

RCL Exception Denial:

The Intermediary improperly denied the Provider's RCL exception request, and the request is remanded to the Intermediary to be determined on its merits. The Intermediary is directed to notify the Provider regarding the additional documentation that must be submitted, and the Provider is to submit the requested information within 45 days from the date of the Intermediary's notification.

[7] HCFA Pub 15-1 §2531.1B3
[8] CMS Pub §13-2 2219.4, 42 CFR §405.1801

Board Members Participating:

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Concurring Opinion of RCL Exception Denial)
Anjali Mulchandani-West

FOR THE BOARD:

DATE: September 16, 2005

Suzanne Cochran
Chairperson

Concurring Opinion of Elaine Crews Powell

Routine Cost Limit Exception Request

I concur with the Board's decision that the case should be remanded to the Intermediary for a decision on the merits of the application as well as with the 45-day time limit for the submission of additional documentation. I would also require that the request be sent via certified mail with proof of delivery and that the Provider's response be handled in like manner.

However, I find that there is wording in the decision that simply goes too far. I cannot agree with the majority's conclusion on page seven where it states:

> . . . the Provider was unable to respond to the Intermediary's letter requesting additional documentation *as it was not received*. . . .
> (Emphasis added.)

I agree with the majority's conclusion that the Provider is being asked to "prove a negative" and that the request for additional documentation from the Intermediary should have been sent with "proof of delivery or proof of mailing." I am uncomfortable with stating as fact what is clearly an opinion, i.e., that the Provider never received the request. Doing so is certainly beyond my powers of clairvoyance.