PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D15

PROVIDER -
Acadian HomeCare, Inc.
Lafayette, Louisiana

Provider No.: 19-7060

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
June 17, 2005

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 02-1526

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ISSUE:

Whether the Intermediary's disallowance of medical director fees was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to 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.

Medicare regulations at 42 CFR §413.20 and 413.24 require that providers maintain sufficient financial records and statistical data for the proper determination of costs payable under the program. 42 CFR §413.9 further requires that, for costs to be allowable, they must be necessary and proper, i.e., costs that are appropriate and helpful in developing and maintaining the operation of the patient care facilities and activities. The issue in this appeal is whether the costs associated with medical director activities are reasonable, necessary and adequately documented.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Acadian HomeCare (Provider) is a home health agency located in Lafayette, Louisiana. The Provider claimed $73,747 in Medical Director fees on its cost report for the fiscal year ended (FYE) 12/31/99. The amount represents fees for 13 Medical Directors covering seven branches, including $18,000 paid to the Agency's Medical Director and $12,040 paid to the Agency's Alternate Medical Director. Palmetto GBA (Intermediary) reviewed the fees and disallowed $42,170. The Intermediary's disallowance was based upon a collective lack of documentation, duplication of services, undocumented on-call

services and non-allowable lobbying activities. The Provider concurred with the disallowance of the lobbying activities ($1,700) but disputes the remaining $40,470 of the disallowance.

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary's adjustment violates Section 2102.1 of the Provider Reimbursement Manual (PRM) which requires the Intermediary to allow reasonable costs for the provision of necessary services. The Provider argues that it provides services across a large rural area that is home to several culturally diverse populations and that its Medical Directors' activities are necessary to ensure quality patient care in the Provider's rural, culturally diverse setting.

The Provider also challenges the Intermediary's finding that services provided by its Alternate Medical Director were duplicative of the activities of the Medical Director and the Nursing Director. The Provider contends that all Medical Director costs were supported by contracts which evidenced that services were provided on a rotational schedule that avoided service duplication among the Directors. Further, the Provider argues that its Medical Director is on call 24 hours a day to provide immediate access for nursing staff who lack legal authority for "on call" services. Since registered nurses lack such authority, it is impossible for these services to be a duplication of their activities.

The Provider also contends that its Medical Director costs were supported by the documentation required in 4112.4B of the Intermediary's audit manual. The documentation demonstrates that the costs for Medical Director services were incurred in a manner consistent with reasonable buyer concepts found in section 2103 of the PRM.

The Intermediary asserts that the Provider's Medical Directors' on call services are a duplication of the services. The Medical Director provides the same services that are traditionally provided by a Nursing Director. Further, the Medical Director is on call 24 hours per day despite availability of the Nursing Director.

The Intermediary also contends that the amounts claimed for the Provider's Alternate Medical Director lacked documentation and duplicated services. The Intermediary asserts that no contract was available for the Alternate Medical Director and invoices submitted for his services lacked detail for the services that he performed. Absent such detail, it appeared that the services provided overlapped with those provided by the Medical Director and Nursing Director.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the Intermediary's adjustment to the Provider's Medical Director fees was proper.

The question for the Board is whether the costs claimed for Medical Directors' services

were necessary and proper. 42 CFR §413.9 (b)(2) states:

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

The language of the regulation requires that the Board examine the nature and scope of the services provided by the Provider's Medical Directors. The record indicates that the Medical Directors were on call 24 hours per day to provide immediate consultation to Provider's nursing staff. Further, the Medical Directors had oversight and administrative duties.

The Board majority finds that the Intermediary properly allowed the documented costs associated with the Medical Directors' oversight and administrative duties actually furnished on behalf of the Provider organization for which the medical directors were paid $200 per hour.[1] These duties include, for example, reviewing patient charts, attending management meetings and helping develop the organization's policies and procedures.

The Board majority is not persuaded, however, of the need for 24 hour on-call service by multiple medical directors who were paid a flat monthly fee for the service. Provider claims this service was necessary to provide immediate consultation to Provider's nursing staff.

Home health visits are not usually provided around the clock. Moreover, as a condition for Medicare payment, home health services must be furnished under a plan of care that is established and periodically reviewed by a patient's attending physician. 42 C.F.R §§424.22 and 484.18.[2] Medicare Part B pays for these direct patient care physician services. 42 C.F.R. 424.24. Proper Medical Director services in the home health agency setting are administrative in nature and are paid under Part A. 42 C.F.R. §484.16.[3] Patient medical needs, both routine and emergency, that arise in a home health environment therefore require communicating with the patient's personal physician or calling a rescue ambulance. Examples cited by the Provider of the type of services expected of the on call Medical Director include circumstances when the treating physician was unavailable, or when, in the opinion of the HHA staff, the treating physician was prescribing inappropriate care.[4] These services clearly appear to be professional medical services, not administrative services. It is not proper or necessary for the home health agency to substitute its medical director's professional medical services for those of the attending physician for direct patient medical services. It is also

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[1] See Intermediary Exhibits I02, I-3 and I-5 and Provider Exhibit P-11.

[2] Generally, the certifying physician cannot be one that has a financial relationship with the home health agency. 42 C.F.R. 424.22(d).

[3] A medical director is not required but the regulations do require that a group of professional personnel, which includes at least one physician, annually review the agency's policies. 42 C.F.R §484.16.

[4] Provider's Supplement Final Position Paper, page 3. The Intermediary did not find evidence that any services were actually provided under the on call arrangement. See Intermediary Exhibits I-2 and I-5.

doubtful that, even if proper, those services could be considered necessary when there was no evidence that the physicians were called upon during the year. The Board majority therefore concludes that the costs incurred for medical directors 24 hour on call services were properly disallowed.

The Provider also argues that its primary objective for employing medical directors is to assure agency –wide consistency in patient care. The Board majority does not find any nexus between this goal and having thirteen medical directors for seven locations.

The Board majority acknowledges that the costs for medical director services did not cause the Provider to exceed applicable cost limits and that its cost per visit was in line with those of its peers. However, where costs incurred are unnecessary, examination of overall reasonableness of the total cost when compared to Provider's peers need not be made.

DECISION AND ORDER:

The Intermediary's adjustment of the Provider's Medical Directors' fees was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S. (Dissenting Opinion)
Elaine Crews-Powell, C.P.A.
Martin W. Hoover, Esq. (Dissenting Opinion)
Anjali Mulchandani-West

FOR THE BOARD:

DATE: February 3, 2006

Suzanne Cochran, Esquire
Chairperson

Dissenting opinion of Gary B. Blodgett and Martin W. Hoover, Jr.

We respectfully dissent with the majority's opinion in this case.

The Intermediary's sole basis for disallowing Provider's on-call costs was that they were unnecessary and a duplication of services. The Intermediary contends that the Director of Nursing performs oversight of the nursing staff, and if medical questions arise which the DON cannot answer, the attending physician would be contacted. Therefore, there is no necessity for the Medical Director to be on-call 24 hours a day, as this function would be a duplication of services with the DON.

The Provider maintains that its Medical Director services were not a duplication of the Director of Nursing services, as a registered nurse is not authorized or capable of providing medical services in an on-call capacity. As for contacting the attending physician regarding medical questions, the Provider contends that although a patient's attending physician should provide immediate access, in reality, that is not the case in the home health environment.

Because Acadian HomeCare services a large area, much of which is remote and rural, Provider maintains that there was a legitimate need to have local physicians readily available to consult with its staff regarding timely and quality patient care under any circumstances; and having a Medical Director for each branch office was more effective in servicing Provider's widely scattered patient base than for one Medical Director to have serviced the entire operation.

The Provider contends that its on-call Medical Director costs were incurred due to the Provider's goal of delivering quality patient care, and that their Medical Directors were under written contract to be on-call 24 hours a day seven days a week so the nursing staff would have immediate access for questions relating to the medical conditions of their elderly patients, even when their own physician might not have been available.

The Provider also maintains that the Intermediary's adjustment was in violation of Section 2102.1 of the Provider Reimbursement Manual, which requires the Intermediary to allow reasonable costs for the provision of necessary services and prohibits the arbitrary and capricious disallowance by the Intermediary. Under reasonable cost reimbursement, providers are reimbursed on the basis of actual costs, even though they may vary from provider to provider; and the only exception is when a provider's costs are substantially out of line when compared to institutions in the area of similar size and scope. PRM §2102.1.

Acadian maintains that it was efficiently operating its HHA and assuring that its patients would have the benefit of a physician's services at all times, and there is nothing in the Medicare regulations or manual instructions that precludes home health agencies from compensating their Medical Directors as Acadian has done.

We find that Provider's on-call Medical Director costs were necessary, reasonable, directly related to patient care by making it possible for the nursing staff to more effectively address the home health care needs of its patients, and NOT substantially out of line when compared to institutions in the area of similar size and scope. The Intermediary's adjustment to those costs should be reversed.

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Gary B. Blodgett

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Martin W. Hoover, Jr.