PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D11

PROVIDER -
Curative Workshop of Racine
Racine, Wisconsin

Provider No. 52-6514

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of
Wisconsin

DATE OF HEARING-
October 20, 1997

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 95-0380

INDEX

ISSUE:

Was the Intermediary's modification of cost reporting form 2088-79 for the calculation of reimbursable cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Curative Workshop of Racine ("Provider") is a voluntary, non-profit Medicare certified Outpatient Rehabilitation facility located in Racine, Wisconsin. Blue Cross and Blue Shield of Wisconsin ("Intermediary") was the Medicare intermediary for the year under appeal. After a desk review of the Provider's cost report, the Intermediary made a modification to the Medicare cost reporting Form 2088-79. The Intermediary changed the form by using the Medicare reasonable costs less actual coinsurance to account for coinsurance payments, rather than using costs and applying the 80% reduction factor as indicated by the forms.

The Intermediary determined that the cost reporting form did not take into consideration the fact that actual coinsurance payments could exceed 20% of reimbursable costs and adjusted the form accordingly. The Provider disagreed with the Intermediary's adjustment and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement in contention is approximately $12,254.

The Provider was represented by Mark K. Hilton, CPA , of Clifton, Gunderson & Company. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the Intermediary did not cite an appropriate law, regulation or instruction on which it based its adjustments to the cost reporting form. The given cite at 42 C.F.R. § 413.24 does not address the Intermediary's change to the HCFA-approved cost report form which has been in use since October 1, 1979. The Provider further argues that the Intermediary does not have the authority to modify a HCFA-approved cost reporting form. The Intermediary must follow the HCFA instructions to the cost reporting forms found in Medicare Provider Reimbursement Manual Part 2 (HCFA Pub. 15-2), at chapter 6. The Intermediary indicated that in the prior year the adjustment was based on verbal authority given by the Blue Cross and Blue Shield Association. The Provider further contends that the Intermediary must use the HCFA-approved form 2088-79 which is required by HCFA Pub. 15-2, § 106 and § 600. In addition, the Intermediary must calculate Medicare reimbursement following the cost reporting instructions found in HCFA Pub. 15-2 at § 620.1.[1] The Provider points out that the cost reporting instructions do not allow an intermediary to arbitrarily

[1] Lines 1 through 17.

modify a cost report. Changes to cost reporting forms must be approved and go through proper disclosure requirements to the public.

The Provider points out that the Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facility Manual, HCFA Pub. 15-9 § 210.2, defines coinsurance as follows:

> Coinsurance - After sufficient expenses have been incurred to satisfy the deductible, the agency or clinic will be reimbursed by the program for 80 percent of the reasonable cost of the covered outpatient physical therapy or speech pathology services which it provided directly or through arrangements with others. The patient is responsible for a coinsurance amount of 20 percent of the reasonable charge for the outpatient physical therapy or speech pathology services furnished.

Id.

The Provider argues that this definition does not state that reimbursement to a provider should be based upon the lower of 80 percent of the reasonable cost or 20 percent of the reasonable charge. In fact the definition is quite clear that the Provider is to be reimbursed 80 percent of the reasonable cost.

The Provider contends that the reimbursement methodology for Outpatient Physical Therapy facilities ("OPTs") has been consistently used since 1979. In this case the Intermediary's treatment is inconsistent with other intermediary calculations of reasonable cost for OPTs. The Provider points out that Blue Cross of Maryland's Medicare Audit department settles OPTs utilizing the HCFA-approved forms and does not modify them in the manner evidenced by this Intermediary. The inconsistent treatment places the Provider in an extreme disadvantage in providing services to Medicare patients and is evidence that the Intermediary's actions are not proper or appropriate.

The Provider further argues that the cost reporting forms and instructions are adequate in calculating Medicare reimbursement in accordance with Medicare law and regulations. The HCFA form 2088-79 and related instructions properly account for any difference in coinsurance based on cost and coinsurance based on charges in the calculation of bad debts through the use of lines 18 through 27.

The Provider contends that the Intermediary improperly modified the HCFA-approved cost reporting forms for the application of Primary Payor amounts. The Intermediary did not utilize Schedule C, line 6 as required by cost reporting instructions, but has modified line 11 for the amount. The Provider points out that the instructions for line 6 state:

> Line 6 Enter on this line any adjustments needed for the cost of services covered by Workmen's Compensation, the Veteran's Administration and

Public Health Service grants for services rendered to health insurance program beneficiaries.

The Provider contends that this line has been used by other intermediaries for primary payor amounts (partial payments made by other sources for Medicare beneficiaries). The payments made by other payers need to be offset to the total provider expenses applicable to the Medicare program because the total statistic (charges) has been used in determining the total expenses applicable to Medicare. The Intermediary's methodology inappropriately uses the primary payor amounts to offset the Medicare provider portion (80% of total Medicare expense).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's methodology in determination of reimbursable costs does not consider the intent of the Medicare regulation at 42 C.F.R. § 413.9 which states in part: "[i]t is the intent of Medicare that payments to providers of services should be fair to the providers, to the contributors, to the Medicare trust funds, and to other patients." The Intermediary further argues that the Provider's methodology results in the Provider being over compensated and causes the Medicare trust funds to be over-utilized. Since the Provider is paid the actual coinsurance monies by the patients, it is only appropriate to use the same monies as a reduction of reimbursable costs to be reimbursed by the Medicare trust funds via the Medicare cost report. The Intermediary further contends that if the 20% factor is used rather than actual coinsurance in the cost report calculation, the Provider is getting paid twice for the excess coinsurance monies, once from the patients directly and again through the Medicare cost report.

The Intermediary points out that before it used actual coinsurance amounts for the settlement computations, it verified this treatment with Blue Cross and Blue Shield Association and HCFA. Blue Cross and Blue Shield Association and HCFA informed the Provider that the cost reporting forms were incorrect and would be revised at a future date.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(A)	-	Reasonable Cost

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

§ 413.9	-	Cost Related to Patient Care
§ 413.24	-	Adequate Cost Data and Cost Finding

3. Medicare Provider Reimbursement Manual, Part 2 (HCFA Pub. 15-2):

§ 600	-	General
§ 620.1	-	Part I - Computation of Reimbursement Settlement

4. Outpatient Physical Therapy Manual, (HCFA Pub. 15-9):

§ 210	-	Deductible and Coinsurance Under Medical Insurance

5. Miscellaneous:

HCFA Form 2088-79	-	HCFA Cost Report

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented finds and concludes that the Provider filed its cost report using the proper cost reporting form. Since the Provider used the proper cost reporting form, the Intermediary was not authorized to unilaterally change that form. Therefore, the Board finds that the Intermediary's adjustment of the cost report form was improper.

The Board finds that the Medicare regulations require a provider to use a specific method of cost apportionment and cost allocation. These methods cannot be changed by a provider without prior approval from its intermediary. Conversely, an intermediary cannot change a cost reporting form without prior notice to a provider. A provider is required to use the forms provided for its specific reporting method and is required to follow the general program instructions in preparing the report. In the present case, the Board finds that the Provider did follow the cost reporting instructions when it prepared its cost report. The Board further finds that the Provider was required to use the forms devised for its cost reporting method and was required to follow the program instructions in preparing the cost report.

The Board finds that the Provider was reimbursed for services rendered by its outpatient department based on 80% of reasonable cost. The Board finds that the Intermediary did not have the authority to change the cost reporting forms.

The Board finds that there was not substantial evidence in the record to support the Intermediary's contention that the Intermediary contacted HCFA and that HCFA approved a change in the cost reporting forms. The Board also finds it unusual that there was no Intermediary letter issued concerning the Intermediary's contention that a change was to be made based on DEFRA 84 to incorporate its interpretation of the proper handling of

coinsurance on the cost reporting forms. Also, the Board finds that although the intermediary claimed the change in the cost reporting form was based on DEFRA 84, there was no information in the record to support that contention.

DECISION AND ORDER:

The Intermediary's adjustment of the cost reporting forms was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

Date of Decision: December 09, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman