PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D14

PROVIDER -Greynolds Park Manor, Inc.
North Miami Beach,
Florida

Provider No. 10-5201

vs.

INTERMEDIARY -
Ætna Life Insurance Company

DATE OF HEARING-
October 31, 1996

Cost Reporting Period Ended -
May 31, 1989

CASE NO. 92-0430

INDEX

ISSUE:

Was the Health Care Financing Administration's (HCFA) denial of the Provider's exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Greynolds Park Manor, Inc. ("Provider") is a 324-bed skilled nursing facility in North Miami Beach, Florida. On its original cost report, the Provider classified respiratory services as an ancillary service.[1] During the desk review of the Provider's May 31, 1989 cost report, Ætna Life Insurance Company ("Intermediary") notified the Provider of its intention to disallow as an ancillary service, cost relating to respiratory services provided to its inpatients.[2] The Intermediary cited the Skilled Nursing Facility Manual (HIM-12) § 230.9 as its reason for disallowing the costs. In response, the Provider requested that the respiratory costs be reclassified to the routine service cost center. A request for an exception to the routine service cost limits due to the provision of atypical services was also made at this time.[3]

On September 29, 1990, the Intermediary issued its desk review report agreeing with the Provider's request to reclassify the respiratory costs from ancillary to routine costs.[4]

On October 10, 1990, the Intermediary notified the Provider that it would begin processing the exception request.[5] On February 19, 1991, the Intermediary forwarded the Provider's request to HCFA for its consideration, stating that the request met the requirements of 42 C.F.R.
§ 413.30(f)(1).[6]

HCFA notified the Intermediary of its denial of the request and the Intermediary subsequently notified the Provider on November 14, 1991. In its letter, the Intermediary outlined HCFA's reasoning for denying the exception request. According to the Intermediary,

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1 Tr. at 7.

2 Provider Exhibit P-1.

3 Provider Exhibit P-2.

4 Provider Exhibit P-3.

5 Provider Exhibit P-4.

6 Provider Exhibit P-6.

> Based on HCFA's review and pursuant to Section 230.9 of HIM-12 regulations, "[a] SNF is permitted to secure diagnostic and therapeutic services for its inpatients from a transfer hospital.[7] The transfer hospital must have the capacity to provide the services directly. If the transfer hospital does not have the capacity to provide the services directly, but provides them through an arrangement with an outside source, these services would not constitute covered extended care services." Based on those facts, the respiratory therapy services performed by the third party on Greynolds Park's inpatients would not be a covered SNF service and not reimbursable as either an ancillary or inpatient service. Accordingly, an exception to the routine cost limit for therapy services cannot be granted.

Provider Exhibit P-7 and Intermediary Exhibit I-2.

On January 10, 1992, the Provider filed a timely appeal of HCFA's determination with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841.[8] The amount of Medicare reimbursement in dispute is approximately $35,000.[9] The Provider was represented by Saul Silverman, C.P.A. The Intermediary was represented by Paul Gulbrandson, C.P.A. of Ætna Life Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that respiratory costs incurred by therapists under the direct supervision of its Director of Nurses are allowable routine service costs that meet the requirements of 42 C.F.R. § 413.30(f)(1) as atypical services. The Provider contends it has met the regulatory criteria established for an exception on the grounds of atypical service. According to the regulations at 42 C.F.R. § 413.30 (f):

> (1) Atypical services. The provider can show that the,

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[7] According to the Provider, it had an agreement with a transfer hospital to provide respiratory therapy services to its patients. The therapists that provided services under this agreement were not employees of the transfer hospital. Provider Post Hearing Brief, Pg. 4.

[8] On May 3, 1995, the Board issued a decision (Intermediary Exhibit I-3) regarding jurisdiction of the Provider's appeal. (The Provider's original appeal (Intermediary Exhibit I-4) included two issues.) The Board indicated that it had jurisdiction only over the issue of the denial of the exception request by HCFA to the Provider. The Board indicated the other issue was filed in an untimely manner and consequently determined it had no jurisdiction over the issue. The Provider agreed. Tr. at 31, ln. 5.

[9] Provider Position Paper at 1.

(i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and

(ii) The atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

Id.

The Provider contends that it was HCFA that erred in basing its denial of the exception request on the provisions of HIM-12 § 230.9[10] and by ignoring the provision of HIM-12 § 230.10[11] relating to the provision of respiratory services by the Provider's nursing staff. The Provider contends that HIM-12 § 230.9 relates only to situations where respiratory services are being billed as an ancillary charge.[12]

The Provider contends that under HIM-12 § 230.10(B)(2)(a), respiratory services are a covered service when provided by the Provider's nursing staff. In the definition of respiratory therapy services under HIM-12 § 230.10(B)(1), it states:

"Such services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel.

To qualify for reimbursement under Medicare, such therapy (1) must qualify as a covered service, and (2) must be reasonable and necessary for the diagnosis or treatment of an illness or injury."

Id.

HIM-12 § 230. 10(B)(2)(a) points out the circumstances under which respiratory therapy would qualify as a covered service. It states:

"Skilled nursing facility - Services furnished in the skilled nursing facility setting would be covered under the posthospital extended care benefit if furnished to the inpatients of a skilled nursing facility by a "transfer hospital" (see § 230.9), or if furnished by a nurse on the staff of the SNF."

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10 Provider Exhibit P-7.

11 Provider Exhibit P-9.

12 Provider Position Paper at 5.

Id.

The Provider believes it is quite clear that the above section is referring to the two methods of providing the service: 1) as an ancillary chargeable service provided by a transfer hospital; or 2) as a routine service provided by the SNF's nursing staff.

The Provider contends that based on the above, in order for respiratory services to be a covered routine service, the therapists must be on the Provider's nursing staff. The Provider maintains it is quite clear in its Procedures and Policy Manual that respiratory therapists work in conjunction with and under the direct supervision of the RN supervisor or charge nurse.[13] The Provider contends that all respiratory therapy services furnished by the Provider were supervised by the Provider's registered nurses.[14] The Provider also contends that a HCFA letter dated May 2, 1991[15] supports its position that respiratory services are covered SNF services when provided under the supervision of the registered nurses.[16]

During the cost reporting period, respiratory therapy services were provided by contract therapists under the direct supervision of the Provider's RN supervisor.[17] The Provider points out that the Intermediary never refuted the fact that the therapists were under the direct supervision of the Provider's Director of Nurses and therefore should be considered as part of the nursing staff. The Provider contends there is no provision in the Provider Reimbursement Manual that prohibits reimbursement for nursing services provided by contract staff versus salaried employees, other than the general reasonable and necessary cost provisions.

Finally, the Provider contends that it has clearly shown that respiratory services were provided under the supervision of its Director of Nurses. Therefore, the contract therapists were members of the Provider's nursing staff and their cost qualified as covered Medicare routine services meeting the requirements for granting an exception to the Routine Service Cost Limitation contained in 42 C.F.R. § 413.30.

In summary, it is the Provider's position that the costs incurred during the cost reporting year ended May 31, 1989 for respiratory therapy services are covered costs and that HCFA's denial of the Provider's Routine Service Cost Limitation exception request, based on their characterization as a non-covered service, should be reversed.

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13 Provider Exhibit P-11, Tr. at 31.

14 Provider Exhibits P-12 and P-13.

15 Provider Exhibit P-10.

16 Provider Position Paper at 6.

17 Provider Position Paper at 7, Tr. at 8, 32.

INTERMEDIARY'S CONTENTIONS:

The Intermediary is in agreement with HCFA's determination that the Provider is not entitled to a routine service cost limitation exception and that their determination was proper and consistent with Medicare law, regulations, and manual instructions.[18] The Intermediary agrees with HCFA's determination that since the therapy costs were not provided directly by the hospital with which the Provider had a transfer agreement, they are non-covered services. Therefore, the Intermediary believes HCFA's determination, which was based on HIM-12, § 230.9, was proper.

The Intermediary acknowledges that it made a mistake when it agreed to reclassify the Provider's respiratory therapy costs from ancillary to routine costs.[19] The Intermediary had originally disallowed these costs as ancillary costs during its initial desk review of the Provider's cost report.[20] The Provider subsequently requested these costs be reclassified to routine costs and the Intermediary obliged.[21] The Intermediary indicated that their original rationale for granting this request was that the Provider was already over the cost caps, therefore, it would not benefit by this reclassification.[22] As stated above, the Intermediary admits this was a mistake on their part.

The Intermediary rejects the Provider's contention that it had direct supervisory responsibility for the contract therapists.[23] The Intermediary points out that according to the affiliation agreement between the transfer hospital and the therapy agency,[24] "[a]ll therapists shall work under the supervision of the affiliate who, in turn, shall be ultimately responsible to the hospital. Periodically, hospital and affiliate representatives shall visit SNF to ensure the provision of services in a quality orientated, efficient and effective manner." Id. The Intermediary maintains the contract is between the supplier of services and the transfer hospital and that the Provider is not a party to the agreement.[25]

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18 Intermediary Position Paper at 3.

19 Tr. at 13, 14, 33.

20 Provider Exhibit P-1.

21 Provider Exhibit P-2.

22 Tr. at 14.

23 Tr. at 11-12.

24 Intermediary Exhibit I-4.

25 Tr. at 11.

The Intermediary also disputes the Provider's contention that the HCFA letter (Provider Exhibit P-10) affirms the Provider's position that respiratory services are a covered service when provided under the supervision of the registered nurses.[26] The Intermediary contends that there is nothing in the record to indicate that therapy employees under contract to the transfer hospital meet the qualifications as outlined in the HCFA letter.[27] The Intermediary argues that the therapists were employees of the respiratory therapy agency and not Provider employees.[28]

In summary, the Intermediary contends that the law, regulations, and manual support HCFA's denial of the Provider's exception request. The Intermediary agrees with HCFA's determination that since the therapy costs were not provided directly by the hospital with which the Provider had a transfer agreement, they are non-covered services. Therefore, HCFA could not grant an exception for atypical services since the services, upon which the exception request was based, are non-covered services.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30(f)(1)	-	Limitations on Reimbursable Costs-Exceptions - Atypical Services
§ 409.27	-	Other Diagnostic or Therapeutic Services

2. Program Instructions-Skilled Nursing Facility Manual - HIM-12:

§ 230.9	-	Other Diagnostic or Therapeutic Services
§ 230.10	-	Other Services

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[26] Tr. at 33 and Provider Position Paper at 6.

[27] Tr. at 33.

[28] Id.

3. Cases:

Mainline Nursing and Rehabilitation Center v. Blue Cross and Blue Shield Assoc./Blue Cross of Greater Philadelphia, HCFA Administrator Decision, November 8, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,255.

Care Enterprises West Group Appeal v. Mutual of Omaha, PRRB Dec. No. 97-D66, June 17, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,452.

4. Other:

HCFA Ruling 83-1- Provider Reimbursement Review Board Decision on Lack of Jurisdiction

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the Provider's post hearing brief, finds and concludes as follows:

The facts in this case are not in dispute. The Provider sought an exception to the routine service cost limits from HCFA due to atypical services being rendered. The services were provided by a hospital with which the Provider had an agreement for the transfer of patients. The services, however, were not provided directly by the transfer hospital as required by the law, regulation and manual provisions. The Board notes that the plain language of HIM-12 § 230.9 is clear in its distinction between services provided directly by the hospital (i.e., covered services) and those provided through an arrangement with an outside source (i.e., non-covered services). The sole basis of HCFA's denial of the exception request was that the services were not furnished directly by the hospital with which the Provider had a transfer agreement.

The Board is not persuaded by the Provider's contention that the therapists worked directly for the Provider's Director of Nursing ("DON") and, consequently, should be covered services. The Board notes that although the DON may have a quasi-supervisory relationship regarding the respiratory therapists providing services in the SNF, the Director was not accountable to the employing therapy agency. The Board draws a distinction between the DON having overall responsibility for services rendered in the SNF and that of a direct employer/employee relationship that existed between the therapists and the outside therapy agency employing them. The Board notes that the respiratory therapy situation within the transfer hospital was not described in the record. There was no evidence that indicated the hospital was subcontracting for its respiratory therapy services.

The Board also notes that although the Intermediary had originally proposed to deny the respiratory therapy costs as ancillary costs in its initial review of the Provider's cost report and then subsequently reclassified them as routine costs, the Intermediary admitted that the reclassification was a mistake on its part.

The Board finds that HCFA determined that the respiratory therapy services were not covered by Medicare. Section 1878(g)(1) of the Social Security Act ("Act"), as amended, prohibits the Board from hearing a determination by an Intermediary/HCFA that Medicare payment cannot be made for items and services that are excluded from coverage. Under 42 C.F.R. § 409.27, diagnostic or therapeutic services provided by a SNF are not covered by Medicare unless these services are provided directly by a hospital with which the SNF had a transfer agreement. In the instant case, the services were not provided directly by the transfer hospital; the services were provided by an unrelated organization. Therefore, the services were not covered by Medicare and the Board does not have jurisdiction. See HCFA Ruling 83-1 and Mainline Nursing and Rehabilitation Center v. Blue Cross and Blue Shield Assoc./Blue Cross of Greater Philadelphia, HCFA Administrator Decision, November 8, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,255, and Care Enterprises West Group Appeal v. Mutual of Omaha, PRRB Dec. No. 97-D66, June 17, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,452.

DECISION AND ORDER:

The Board does not have jurisdiction over this appeal and hereby dismisses it.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman