PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D18

PROVIDER -
California Special Care Center
La Mesa, California

Provider No. 05-5632

vs.

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

DATE OF HEARING-
September 30, 1997

Cost Reporting Period Ended -
December 31, 1991

CASE NO. 93-1769

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ISSUE:

Was the Intermediary classification of the salaries of restorative nursing aides from the physical therapy cost center to the routine cost area proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

California Special Care Center (CSCC) ("Provider") is a proprietary skilled nursing facility located in La Mesa, California. In its December 31, 1991 cost report the Provider included the salaries for restorative nursing aides in the physical therapy cost center. Blue Cross of California, ("Intermediary") removed the salaries for restorative therapy aides and reclassified the cost to the routine, participating and non-participating, cost center. As support for its adjustment the Intermediary cited the Health Insurance Manual for Skilled Nursing Facilities ("HCFA Pub. 15-12") which provides instructions for implementation of the provisions of Title XVIII of the Social Security Act and Medicare regulations as they relate to extended care benefits.

The Provider appealed its Intermediary's adjustment to 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 amount of Medicare reimbursement in controversy is approximately $25,047.

The Provider was represented by Jerry R. Katz, CPA of Katz Accountancy Corporation. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it met the criteria for reimbursement for restorative aide wages as promulgated in the Medicare Part A Intermediary Manual Part 3, ("HCFA Pub.13-3") § 3101.8D, and the revised Medicare Carrier Manual, ("HCFA Pub. 14-3"), transmittal 1544. The Provider also points out that its position was enhanced by the PRRB decision in American Health Services, Inc. d/b/a The Clairmont - Taylor v. Mutual of Omaha Insurance Co., PRRB Dec. No. 97-D42, April 1, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,168, rev'd HCFA Administrator, June 9, 1997, and American Health Services, Inc. d/b/a The Clairmont - Beaumont v. Mutual of Omaha Insurance Co., PRRB Dec No. 97-D44 April 7, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,170 aff'd HCFA administrator, June 10, 1997.

The Provider argues that those decisions defined an ancillary cost. Within that definition it was determined that an item would be considered an ancillary cost if it were not routinely furnished to all patients, would not be used by patients in small quantities, were not a reusable item, and could be directly identifiable to a specific patient at the direction of a physician due

to a specific medical need.

The Provider contends that it met the requirements as mentioned by the PRRB in the above cited decisions and also met the intent of ¶ 3101.8D of HCFA Pub. 13-3 which are:

1) The services must be medically necessary
2) Treatment must be prescribed by a physician
3) Services must be performed by employees of the physical therapy department of the provider
4) The costs must be reasonable
5) Charges must be equally imposed

The Provider points out that the Intermediary agreed that the Provider met the first four requirements. The Provider argues that the Intermediary would like the Board to believe that the terminology in HCFA Pub. 13-3 § 3101.8 D requires that restorative aides services must be billed separately. The Provider contends that this mistaken belief is based upon a convoluted interpretation of the language which states: "if all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes." Id. The Provider argues that the Intermediary erred in interpreting the word "can" in the aforementioned passage for the word "must". It is common knowledge that the word "can" is synonymous with the word "may", while "must" means that it is a requirement. Nowhere in the regulations does the word, "must" appear.

The Provider contends that it has met all of the requirements of HCFA Pub. 13-1 § 3101.8D including No. 5. The methodology by which it has met requirement No. 5 includes:

The budgeting process
Worksheet C of the as-filed HCFA 2540-86
Admission rate sheets provided all patients upon admission.

Also the Provider included charges for restorative therapy services insofar as these services are applicable only to Medicare Part A patients, which the witness for the Intermediary testified were billed.

The Provider also points out that in the Intermediary's testimony it was stated that based upon the reclassification, a proper adjustment should have included a reclassification of the revenue included in the Provider's books and records relative to the reclassification costs. Only upon said reclassification of revenue, would there be a proper ratio of cost to charges on Worksheet C.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that ancillary services are defined in the Provider Reimbursement Manual ("HCFA Pub. 15-1") at § 2202.8 as services for which there is a charge in addition to the routine room and board service charge. The Intermediary contends that covered therapy services, including physical therapy, are services related to an active written treatment regimen established by a physician and administered by a licensed physical therapist with the goal of improving the patients' condition.[1] Routine restorative therapy is not considered a covered therapy as general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes.[2]

The Intermediary contends that the Medicare program recognizes certain routine therapy services and permits reimbursement through the physical therapy cost center if the five criteria described in HCFA Pub. 15-12 § 230 are met.[3] Of the five criteria, only one was at issue in this case. The criteria is that the charge for the restorative service must be imposed on all patients. The requirement is followed by the language in § 230.d which states: "[i]f all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes." The Intermediary argues further that the requirement of HCFA Pub. 15-12 § 230.3(d) is clear on its face. If the service is ancillary, then it is performed for a particular patient and the charge is for that particular patient.[4]

The Intermediary points out that the Provider did not have a charge for routine restorative services. The Provider charged patients for physical therapy services, and argued that the physical therapy charge included routine restorative therapy. The Provider's witness admitted that the patients receiving routine therapy services are not also receiving physical therapy "[t]hey're discharged from PT, and that is specifically what this code section deals with, are those patients that may require other than PT."[5] The Provider's witness went on to say that the patient receiving restorative services may not have had physical therapy services for a

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1 Tr. at 9.

2 Tr. at 33.

3 See also HCFA Pub. 13-3 § 3101.8D.

4 Tr. at 34.

5 Tr. at 21.

year.[6] Yet that patient would not be billed for restorative therapy services.[7] The Intermediary points out that under this arrangement, a patient who never received any physical therapy and therefore was never charged for physical therapy, could receive restorative therapy services at no charge.[8]

The Intermediary further points out that there is no charge for restorative services, and no match between a patient receiving a service and charges to the specific service. A patient who receives physical therapy, but does not receive restorative services at any time is charged the same amount as a patient who receives physical therapy and restorative therapy.[9] This supports the Intermediary's position that the charge is for physical therapy service, not restorative therapy, since it is only when the patient is receiving physical therapy that a charge is levied. Indeed, there is no certainty that the patient will ever receive restorative therapy.

The Intermediary argues that the restorative aides generally work in the routine area of the Provider, helping with daily living, dressing, and feeding of patients. Since there is no charge imposed on patients receiving routine restorative services, it is more appropriate to reclassify the cost to routine and average the cost among all patients who might be receiving the service. This allocation is required under the Medicare program instructions, and is reasonable since there is no proof that patients receiving physical therapy are also receiving restorative therapy or that only patients receiving physical therapy services are receiving restorative services.

CITATION OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)A)	-	Reasonable Cost

2. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2202.8	-	Ancillary Services
§ 2304	-	Adequacy of Cost Information

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6 Tr. at 23.

7 Tr. at 25.

8 Tr. at 28.

9 Tr. at 27.

3. Program Instructions - Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

§ 328 - Worksheet B - Cost Allocation

4. Health Insurance Manual for Skilled Nursing Facilities (HCFA Pub.15-12):

§ 230.3(d) - Coverage of Services for Routine Services

5. Medicare Part A - Intermediary Manual Part 3 (HCFA Pub.13-3):

§ 3101.8 D - Routine services

6. Medicare Carrier Manual (HCFA Pub. 14-3):

Transmittal No. 1544 - June 1, 1996

7. Cases:

American Health Services, Inc. - d/b/a The Clairmont - Taylor v. Mutual of Omaha Insurance Co., PRRB Dec. No. 97-D42, April 1, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,168, rev'd HCFA Administrator, June 9, 1997.

American Health Services, Inc. - d/b/a The Clairmont - Beaumont v. Mutual of Omaha Insurance Co., PRRB Dec. No. 97-D44, April 7, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,170, aff'd HCFA Administrator, June 10, 1997.

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 post-hearing briefs, finds and concludes that the Provider did not meet all of the requirements of HCFA Pub. 12 § 230.3(d), and therefore cannot claim the restorative aide cost as an ancillary cost.

The Board finds that there are five requirements which must be met for a Provider to claim the restorative aide cost as an ancillary service. The requirements are found in the Medicare Skilled Nursing Facility Manual ("HCFA Pub. 12") § 230.3(d) which states:

> Many skilled nursing facility inpatients who do not require physical therapy services do require services involving procedures which are routine in nature in the sense that they can be rendered by supportive personnel, e.g., aides or nursing personal, without the supervision of a qualified physical therapist. Such services as well as services involving activities to promote over-all fitness

> and flexibility and activities to provide diversion or general motivation, can be reimbursed through the physical therapy cost center even though they do not constitute physical therapy for Medicare purposes, if:
>
> - The services are medically necessary;
> - The treatment furnished is prescribed by a physician;
> - All services are provided by salaries employees of the physical therapy department of the provider;
> - All services incurred are reasonable in amount (i.e., the employees' salaries are reasonably related to the level of skill and experience required to perform the services in question); and
> - Charges are equally imposed on all patients,
>
> If all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes.

Id.

The Board finds that the Provider met the first four requirements of the manual section, but did not meet the last requirement which states: "charges are equally imposed on all patients." The Board finds that although the Provider argues that the charge for the restorative aide was included in the physical therapy charge, there was no evidence presented to show the amount of the restorative aide charge or that it was imposed on all patients. There was testimony at the hearing[10] that there were patients who received physical therapy services and also received restorative care services. However, there were also patients who did not receive physical therapy services but who did receive restorative care services. Since the Provider contends that the charge for restorative care was included in the physical therapy charge, the patient receiving only restorative care was not charged for that care. Therefore, the Board concludes that charges were not equally imposed on all patients, and therefore the fifth requirement of the HCFA Pub. 12
§ 230.3(d) was not met.

The Board concludes that since there was no separate charge for restorative therapy services, there was no match between a patient receiving a service and charges for the specific service. A patient who received physical therapy but did not receive restorative services was charged the same amount as a patient who received physical therapy and restorative therapy.

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[10] Tr. at 28.

The Board notes that the Intermediary identified the amount of restorative aide cost that should be moved and was moved from the physical therapy ancillary cost section to the routine cost area. However, there was no adjustment of the physical therapy charges that were related to the amount of cost moved to the routine cost area. This causes the ancillary area to have a distorted amount of charges and distorts the cost of the physical therapy ancillary department. Therefore, the Board orders the Intermediary to determine the amount of charges associated with the cost that was transferred to the routine cost center. Those charges should also be deleted from the physical therapy cost center, and the physical therapy cost should be recalculated based on the adjusted physical therapy charges. By reclassifying the charges, there would be a proper ratio of cost to charges.

DECISION AND ORDER:

The Intermediary's adjustment reclassifying the salaries of restorative nursing aides from the physical therapy cost center to the routine cost center was proper. The Intermediary's adjustment is affirmed. The Intermediary is to also adjust the physical therapy charges pursuant to the Board's instructions.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman