# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

99-D50

**PROVIDER** -
Barry Healthcare Services, Inc
Milwaukee, Wisconsin

Provider No. 52-7143

**vs.**

**INTERMEDIARY** -
Blue Cross and Blue Shield Association/United Government Services - Blue Cross and Blue Shield United of Wisconsin

**DATE OF HEARING-**
May 15, 1998

Cost Reporting Periods Ended -
December 31, 1992 and 1993

**CASE NOS.** 95-0523 and
96-0510

**INDEX**

Page No.

ISSUE:

Were the Intermediary's adjustments to reclassify certain costs and visits from skilled nursing to either "other visits" or "private duty visits" proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Barry Healthcare Services, Inc. ("Provider") is a proprietary home health agency located in Milwaukee, Wisconsin. During the desk reviews of the Provider's cost reports for the fiscal years ended December 31, 1992 and 1993, Blue Cross and Blue Shield Association/United Government Services - Blue Cross and Blue Shield United of Wisconsin ("Intermediary") determined that certain services which the Provider classified as skilled nursing visits were actually private duty visits and not "Medicare-like" visits. The Intermediary drew its conclusion regarding private duty nursing based upon the number of hours of service the Provider's patients received. To bring the Provider's costs into compliance with the Intermediary's interpretation of the relevant regulations and program instructions, the Intermediary reclassified these visits and the associated salaries and fringe benefits into a non-reimbursable cost center for private duty nursing. The amounts in dispute for the fiscal years in contention are as follows:

Fiscal Year 1992 Cost Report:

| Visits: | As Filed | As Adjusted | Increase (Decrease) |
|---|---|---|---|
| Skilled Nursing Care-Other | 4,358 | 2,062 | (2,296) |
| Skilled Nursing Care-Total | 4,961 | 2,665 | (2,296) |
| Other Visits/Total | 1,462 | 3,758 | 2,296 |
| **Salaries/Benefits Costs:** | | | |
| Skilled Nursing Care | $399,186 | $ 84,196 | $(314,990) |
| Other Services | $ - 0 - | $314,990 | $ 314,990 |

Fiscal Year 1993 Cost Report:

| Visits: | As Filed | As Adjusted | Increase (Decrease) |
|---|---|---|---|
| Skilled Nursing Care | 3,879 | 1,736 | (2,143) |
| All Other Services | 2,209 | 4,352 | 2,143 |
| **Salaries/Benefits Costs:** | | | |
| Skilled Nursing Care | $335,595 | $ 77,327 | $(258,268) |
| Private Duty Nursing | $ - 0 - | $258,268 | $ 258,268 |

The Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board ("Board"), and has met the jurisdictional requirements of 42 C.F.R. §§405.1835 -.1841. The amounts of Medicare reimbursement in contention are approximately $32,000 and $17,000 for fiscal years 1992 and 1993, respectively. The Provider was represented by Maureen A. Molony, Esquire, of Beck, Chaet, Molony and Bamberger, S.C., and Thomas Ward, Esquire, of Lorenz and Associates. The Intermediary's representative was Bernard M.Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the services at issue are allowable costs and should be included in the skilled nursing cost center on its Medicare cost reports. Contrary to the Intermediary's determinations, there is no basis either in law or in fact for the reclassification adjustments which placed the services rendered to certain patients into a non-reimbursable cost center for private duty nursing. The Intermediary is attempting to circumvent program policy by apportioning costs between Medicare and non-Medicare beneficiaries before allowable costs are determined. The Medicare program essentially has a three-step process to calculate reimbursement as follows:

1. Determine costs;
2. Remove non-allowable costs; and
3. Apportion allowable costs between Medicare and non-Medicare payors.

The apportionment regulation at 42 C.F.R. § 413.53(a)(3) calculates step 3 above to determine the Medicare program's share of total reimbursable costs. Under the regulation, total allowable costs are divided by total visits to determine the proper share of costs that Medicare should pay. The apparent basis of the policy is a belief that non-covered services use more overhead than Medicare services. Even though the like-kind policy is based on step 3 above, the Intermediary improperly removed the like-kind costs in the determination of allowable costs under step 2. Thus, the Intermediary has failed to follow the mandated sequence of the regulations.

The Provider argues that the services at issue were not private duty nursing services. In the absence of a Medicare regulation which defines private duty nursing services, the Intermediary relies on the Medicaid regulation at 42 C.F.R. § 440.80, which has not been adopted by the Medicare program for home health agencies. Although no Medicare definition for private duty nursing exists, the Medicare program does define " private duty" in its instructions to intermediaries for inpatient hospital services. The manual instructions in the Medicare Part A Intermediary Manual ("HCFA Pub.13-3") state the following:

> Private-duty nurses or private duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse attendant. Such persons are engaged or paid by an individual patient or by someone acting on his behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such non-covered services.

HCFA Pub. 13-3 § 3102.1

Under this definition, a private duty nurse is hired to provide care in addition to that already provided by the hospital and ordered by a physician. Contrary to the provision of such luxury service, the Provider in the instant case engaged no nurse to perform services beyond those ordered by the attending physician which were medically necessary. The Provider notes that this interpretation seems to be borne out by the Medicaid program whose regulation defines private duty nursing as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or nursing facility. Accordingly, there were no private duty services under the Medicaid definition since care was available from the home health agency's staff, and no services beyond those considered medically necessary were rendered.

At the hearing, the Provider's witness testified that, based upon her review of the records for the patients at issue, all of the patients required the skill of a nurse to attend to their medical condition.[1] For example, patient "ED"[2] received frequent oral and throat suctioning to prevent aspiration and pneumonia, was feeding through a tube that was in his stomach, and also had frequent seizures and received seizure precautions. In another example, "LS" lived alone, was ventilator dependent (which made it impossible for LS to sleep through the night without intervention), and his food and medications were given through a nasal-gastric tube. A third example, "DB", needed a nurse to evaluate his bowel movement and bladder (DB was incontinent), to suction his tracheostomy and to monitor his overall unstable condition. The Provider contends that the care provided to ED, LS, and DB is representative of the care provided to the other patients at issue.

It is the Provider's position that the care provided to all the patients at issue required the skill of a nurse.[3] The Provider bases this contention, in part, on the fact that these patients'

---

[1] Tr. at 49-61.

[2] The non-Medicare patients at issue are referred to by their initials to avoid disclosure under the Privacy Act.

[3] Tr. at 71-76.

illnesses were so severe that the patients were at risk of experiencing a catastrophic episode at any time. Therefore, even when the nurse was merely observing the patient, the skills of the nurse could be required at anytime. If the patient was being observed by an individual without the skills of a nurse when the patient needed skilled intervention, the unskilled observer would be unable to appropriately intervene, and mere observation would serve no purpose. Therefore, the observation and assessment services provided to the patients at issue required the skill of a nurse (or the skills of a licensed practical nurse under the supervision of a registered nurse) in order to be safe and effective.

The Provider further contends that the patients at issue also met the eligibility requirements set forth in a memorandum from the Health Care Financing Administration ("HCFA"), dated August 1, 1997.[4] That memorandum sets forth the following five criteria for home health service coverage:

1. Confined to the home;
2. Under the care of a physician;
3. In need of skilled nursing or therapy services on a part-time or intermittent basis;
4. Under a plan of care; and
5. Receiving services from a home health agency.

As to the criteria that a patient must require part-time or intermittent skilled services, the Provider refers to § 206.7 of the Home Health Agency Manual ("HCFA Pub. 11"). In defining "skilled and intermittent care," the manual states that such services included "[u]p to 35 hours per week of skilled nursing and home health aid services combined for less than 8 hours per day." While the Intermediary uses the 35 hours per week as a standard for home health services, the Provider insists that this criterion has no basis in Medicare policy. In defining "part-time or intermittent services," the provisions of HCFA Pub. 11 § 206.7C recognize that care above 35 hours may occur as follows:

> Home health aide and/or skilled nursing care in excess of the amounts of care that meet these definitions of part-time or intermittent may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent.
>
> Example: A patient needs skilled nursing care monthly for a catheter change and the HHA also renders needed daily home health aide services 24 hours per day that will be needed for a long and indefinite period of time. The HHA bills Medicare for

---

[4] Provider Exhibit 13.

> the skilled nursing and home health aide services that were provided before the 35th hour of service each week and bills the patient (or another payer) for the remainder of the care. If the Intermediary determines that the 35 hours of care are reasonable and necessary, Medicare would cover the 35 hours of skilled nursing and home health aide visits.

HCFA Pub. 11 § 206.7C

Consistent with the manual provision, the Provider notes that the Board also rejected the Intermediary's contention that visits longer in duration than a "skilled nursing visit" should be considered "private duty nursing." The Board's decision in Confident Home Health Care v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Decision No. 98-D5, October 31, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,760 found nothing in the evidence which defined "private duty nursing." The Board further noted that neither the regulations nor the Provider Reimbursement Manual link hours and visits for skilled nursing care. The Provider believes the Board should similarly rule in the instant case that skilled services do not become some other type of service merely because of their duration.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments were necessary in order to meet the objectives stated under 42 C.F.R. § 413.9 which states:

> The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

42 C.F.R. § 413.9(b).

Pursuant to the regulatory provisions of 42 C.F.R. § 413.53 (a)(3), home health agencies are required to use the cost per visit methodology to apportion costs between Medicare patients and other patients. In applying this methodology, the total allowable costs for each type of service is divided by the total number of visits for that type of service. Based on its review of the Provider's cost reports and additional information requested, including the logs for skilled and licensed practical nursing visits and associated hours,[5] the Intermediary determined that the costs for skilled nursing visits were exceedingly high and that different types of services were being performed. Further review of patient records and nursing reports revealed that many of the patients were actually "private duty" patients and not "Medicare-like "visits." It

---

[5] Intermediary Exhibits 1 and 2.

was further determined that the vast majority of the nursing time spent for these patients was during the overnight hours.

Given the fact that "private duty services" are not "skilled nursing services" covered under the Medicare program, a separate non-reimbursable cost center needed to be established to separately capture these types of services for the proper apportionment of costs. The Intermediary insists that the proper classification of the types of services rendered is an inherent requirement of the apportionment concept that is applied through the cost reporting process. The inclusion of "extended care" visits with services performed for "skilled nursing" visits results in an excessively high cost per visit due to the high costs involved for the low number of related visits. This results in the Medicare program receiving more than its fair share of costs in violation of the basic reimbursement tenet established under 42 C.F.R. § 413.9.

The Intermediary maintains that the requirements and conditions for the reimbursement of home health services under the Medicare program are clearly established under the provisions of 42 C.F.R. § 409.40 and § 409.42. Pursuant to these regulations, nursing care and the services of a home health aide must be performed on a part-time or intermittent basis under a plan of treatment that is established and periodically reviewed by the patient's physician. It is the costs that fall under the umbrella of these two regulations and accumulated in their respective cost centers that are used to apportion costs to the Medicare program. While the Intermediary was unable to find a Medicare program definition of "private duty nursing services," the Medicaid program provides a definition at 42 C.F.R. § 440.80 which is consistent with the day-to-day working definition used by the Medicare program. This regulation states the following:

> Private Duty Nursing Services.
>
> > "Privates duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility.

42 C.F.R. § 440.80.

The Intermediary argues that a key factor in determining Medicare reimbursement is that the types of services used in the apportionment formula have to be basically the same, whether or not the patient has Medicare eligibility. The inclusion of patients who receive full-time care around the clock over a period of years is not the same as an episodic intermittent Medicare visit under a doctor's treatment plan that is periodically examined as to the need for the service and the likelihood of success.

It is the Intermediary's conclusion that it was required to make the reclassifications of the related costs and visits from "skilled nursing" to "private duty nursing" in order to meet the requirements of 42 C.F.R. § 413.9 and § 413.53.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

| | | |
|---|---|---|
| §§ 405.1835-.1841 | - | Board Jurisdiction. |
| § 409.40 | - | Home Health Services Under Hospital Insurance - Included Services. |
| § 409.42 | - | Requirements and Conditions for Home Health Services. |
| § 413.9 et seq. | - | Cost Related to Patient Care |
| § 413.53 et seq. | - | Determination of Cost of Services to Beneficiaries |
| § 413.53 (a)(3) | - | Cost per Visit by Type of Service Method - HHAs |
| § 440.80 | - | Private Duty Nursing Services |

2. Program Instructions - Home Health Agency Manual (HCFA Pub. 11):

| | | |
|---|---|---|
| § 206.7 et seq. | - | Part-Time or Intermittent Home Health Aide and Skilled Nursing Services. |

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

| | | |
|---|---|---|
| § 3102.1 | - | Private Duty |

4. Case Law:

Confident Home Health Care v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 98-D5, October 31, 1997, Medicare & Medicaid Guide (CCH) § 45,760.

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 submissions, finds and concludes that the Intermediary inappropriately reclassified the costs and visits for the services at issue to a non-reimbursable cost center for private duty nursing.

The Board finds that the Intermediary's determinations were based strictly on a cost analysis of data reflected in the Provider's cost reports and the review of various accounting and statistical records subsequently submitted by the Provider at the Intermediary's request. However, the record is void of any medical analysis performed by the Intermediary to determine the types of services actually received by the patients, which would have confirmed the level of care furnished during the home visits. Due to the lack of evidence and medical testimony by the Intermediary, the Board finds no basis to concur with the Intermediary's determination of the types of services rendered.

While no medical determinations were made by the Intermediary, the Provider's Director of Nursing conferred significant proof of the types of services furnished to the patients at issue during her testimony before the Board.[6] The Board finds the clinical evidence presented by the Provider's witness to be persuasive in justifying that the patient visits at issue were "Medicare-like" visits which required skilled nursing services. Given the inherent complexity of the services at issue, the conditions of the patients at issue, and the accepted standards of medical and nursing practices, the observation and assessment services provided to these patients required the skills of a nurse to be safe and effective. The Intermediary presented no evidence to rebut the medical necessity or the level of care rendered to the non-Medicare patients at issue.

The Board rejects the Intermediary's contention that the visits in controversy are non-reimbursable private duty nursing services because they are significantly longer in duration than an actual skilled nursing visit. The Board notes that, while the Intermediary presented various explanations of what constitutes private duty services, no evidence was introduced which defined "private duty nursing" under the Medicare program. As to the duration of the visits, neither the regulations nor the manual instructions link hours with visits for skilled nursing care.

The Board finds that the Provider did incur allowable costs in providing skilled nursing services to non-Medicare covered patients, and that the Provider's method of counting visits was correct. Accordingly, the Board concludes that all the visits which were reclassified as "private duty nursing" or "other visits" should be included in the total skilled nursing visit count as reported by the Provider on its Medicare cost reports.

---

[6] Tr. at 43-101.

DECISION AND ORDER:

The Intermediary's adjustments to reclassify certain costs and visits from skilled nursing to either "other visits" or "private duty visits" were not proper. The Intermediary's determinations are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

**Date of Decision**: June 09, 1999

FOR THE BOARD

Irvin W. Kues
Chairman