PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D56

PROVIDER - Sunbelt Health Care Centers, Inc., Group Appeal

Provider No. Various (See Appendix

vs.

INTERMEDIARY - Various (See Appendix I)

DATE OF HEARING- May 6, 1999

Cost Reporting Period Ended - December 31, 1993

CASE NO. 96-0174G

INDEX

ISSUE

Were the Intermediaries' adjustments eliminating or disallowing the Providers' "gross-up" of drug charges and costs in order to allocate indirect costs to those cost centers correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sunbelt Health Care Centers, Inc. ("Sunbelt") is filing a group appeal for skilled nursing facilities ("Providers") located in Florida, Indiana and Kentucky. Seven of the Providers were owned and operated by Sunbelt. Two of those Providers have subsequently been sold. The remaining two Providers were operated by Sunbelt. For the year ended December 31, 1993, three of the Providers used the "grossing-up" method of allocating overhead costs related to the provision of drug services as described in Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1.") § 2314. The remaining six providers did not initially file their cost reports using the "grossing-up" method. Rather, upon audit of the cost report, they proposed to their Medicare fiscal intermediaries, Ætna Life Insurance Company and AdminaStar Federal-IN ("Intermediaries") that they be allowed the use of the "grossing-up" method.

The Intermediaries denied the Providers the right to use the "grossing-up" method and made adjustments that disallowed the allocation of any overhead costs to the drug cost center. As a result Medicare reimbursed only the direct cost of the drugs and did not recognize any allocation of overhead costs to the drug cost centers at the Providers. This resulted in denying the Providers approximately $103,000 of Medicare reimbursement.

The Intermediaries based their denial of the use of the "grossing up" method on HCFA Pub. 15-1 § 2314ff which states that to use the "grossing-up" method a provider must receive an intermediary's written approval to do so within 90 days after the beginning of the applicable cost report period. The parties agree that the Providers in this case did not seek nor receive such approval.

During 1993, the Providers had contractual and billing arrangements with independent contractors for the provision of drugs to the Providers' patients. Under this agreement, the Providers would bill the Medicare program for drugs rendered to Medicare Part A and Part B patients. The Providers paid the contractors for those services and included the costs in their drug cost centers. The contractors were responsible for billing and collecting for all other patients receiving drugs rendered at the Providers. These included Medicaid patients and private pay patients. The Providers' records did not include costs and billing data for those patients.

The Providers either used or proposed use of the "grossing-up" method of apportioning indirect costs for these ancillary services. This was or would be accomplished by "grossing-up" the direct costs for drugs, including the total costs of drugs for all patients, and placing them in the appropriate cost center. The Providers' total charges were or would also be

"grossed-up" to include charges made by the independent contractors for Medicaid patients and private pay patients receiving these services at the Providers' facilities. At that point, an overhead allocation was or would be applied to the direct costs through step down cost reporting with the resulting overhead cost being apportioned to Medicare based on the ratio of Medicare charges to total charges.

The Providers' appealed the Intermediaries' determinations to the Provider Reimbursement Review Board ("Board"). The Providers' filings meet the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Providers are represented by James Hodson, CPA, of BDO Seidman, LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the Medicare Act requires that skilled nursing facilities ("SNFs") be reimbursed the reasonable cost of their covered services to program beneficiaries. 42 U.S.C. § 1395x(v)(1)(A). Under the statute, the Secretary of Health and Human Services ("Secretary") is given the authority to develop and implement regulations to determine the reasonable cost of services. The first of these provisions, commonly known as the prohibition on cross subsidization, mandates that Medicare is responsible for reimbursing the reasonable cost of services attributable to its beneficiaries. Medicare will not rely on other patients or payers to foot any part of Medicare's share of this cost. Conversely, Medicare will not bear any portion of the costs attributable to non-Medicare patients. The second of these provisions is to make adjustments on a retroactive basis, i.e., looking backwards after the costs have been incurred and reported whenever its cost methods produce reimbursement that is less or more than reasonable costs. Obviously, this can result either in additional payments to a provider when aggregate reimbursement has been inadequate or in recoupments from a provider when that reimbursement has been excessive. Notably, both of these provisions are also reflected in the Secretary's regulations in 42 C.F.R. §§ 413.5(a) and 413.9(b).

The Providers note that 42 C.F.R. §§ 413.20 and 413.24 deal generally with providers' financial data and reports and with adequate cost data and cost finding. HCFA Pub. 15-1 § 2314 specifies the various methods of allocating indirect costs when ancillary services such as drugs are furnished to a provider's patients by others under arrangement. Under HCFA Pub 15-1 § 2314.A, it is not permissible to allocate indirect costs to a cost center which includes only Medicare costs. This would result in excessive allocation of indirect costs to Medicare because it would not reflect the indirect costs attributable to non-Medicare patients. Accordingly, when a provider has only Medicare statistics, it may not allocate indirect costs to a cost center. Rather, total indirect costs must be allocated to all other departments so that they absorb those costs proportionately. By eliminating overhead for any costs that would otherwise include Medicare-only services or statistics and allocating these costs to other cost centers, the Medicare program will share in such indirect costs in the proportion that it shares in the costs of all other services furnished directly by the provider.

The Providers observe that the issue presented in this appeal has previously been resolved by the Board in favor of the Providers' position. See Florida Life Care, Inc. Group - "Gross Up" v. Ætna Life Insurance Co., PRRB Hearing Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide ("CCH") ¶ 38,522 ("Florida Life Care"), Sunbelt Health Care Centers Group Appeal - v. Ætna Life Insurance Co., PRRB Hearing Dec. No. 97-D13, December 3, 1996, Medicare & Medicaid Guide ("CCH") ¶ 44,923 ("Sunbelt"); and, Pinnacle Care Drug "Gross-Up" Group Appeal v. Ætna Life Insurance Co., PRRB Hearing Dec. No. 97-D41, March 26, 1997, Medicare & Medicaid Guide ("CCH") ¶ 45,167 ("Pinnacle Care"). There are no material differences between this case and in the cases presented above. There have been no intervening developments that would warrant a different result here. Accordingly, as the Providers have shown, the Board should hold that the Intermediaries' adjustments were in error, and that the Intermediaries must accept the Providers' use of the "grossing up" method for the period in dispute.

The Providers argue that the Board's rulings are directly on point. In Florida Life Care, Sunbelt , and Pinnacle Care, the facilities had contractual and billing arrangements with outside suppliers for the provision of various services such as physical therapy, occupational therapy, speech pathology, and pharmacy services. The therapy agreements with the suppliers made the facilities responsible for billing for Medicare Part A patients. The suppliers would handle billings not only for Medicare Part B patients but also for Medicaid and private pay patients. The facilities employed the "gross-up" method to allocate overhead costs to these cost centers. The intermediaries adjusted the cost reports to use the "no overhead allocation" methodology because the facilities had not made a timely request to use the "gross-up" methodology under PRM § 2314.B.

In ruling in the facilities' favor, the Board explained that:

> Clearly, the "gross-up" method results in a more accurate cost finding approach. As such it is consistent with the Medicare law and regulations. The Board does give weight to, but is not bound by, the PRM. In this case, it finds that the 90-day PRM limit for granting permission to use the "gross-up" techniques is unreasonable because missing the 90-day deadline results in less accurate cost findings. This results in an improper underpayment of the Providers' costs and conflicts with 42 U.S.C. § 1395x(v) and 42 C.F.R. § 405.402 [now 42 C.F.R. § 413.5] . . . . The Board finds that a PRM section timing requirement should not prohibit the Providers from using a more accurate cost finding methodology. Moreover, an intermediary

> approval to "gross up" charges should not be necessary because this methodology is the correct, most accurate method of determining costs in such a situation.Florida Life Care, Medicare & Medicaid Guide (CCH) ¶ 38,522 at 22,946.

The Board also analogized this situation to circumstances in which a provider offers both in-house and outside laboratory services and "grosses-up" laboratory charges. Significantly, in such circumstances, no prior intermediary approval is necessary and, indeed, "grossing-up" is mandatory. Id. In short, the Board addressed the same issues in Florida Life Care, Sunbelt, and Pinnacle Care and unanimously ruled in favor of the Providers' position. The Providers incorporate the arguments made in Florida Life Care, Sunbelt, and Pinnacle Care by reference.

The Providers argue that the facts in this appeal do not differ in any meaningful way from those in the above cases. In all cases, the providers did not seek or receive intermediary approval to use the "grossing-up" method within 90 days of the applicable cost report periods. In Florida Life Care, there was evidence that intermediaries had not enforced the 90 day rule. Also, in this case, the intermediary even conceded that it was not aware of any instance in which a request to use the "grossing-up" method was denied. In Florida Life Care and Sunbelt, the intermediaries also did not argue or establish that the providers lacked the appropriate records or documentation to use the "grossing-up" method. In our case contrary to the lead Intermediary's position, the Intermediary did not establish that the Providers lacked their appropriate documentation during their audit of the filed cost reports. In fact the fiscal Intermediary's explanation and Medicare regulatory reference for the audit adjustments are based solely on the Providers failure to receive approval to "gross-up". It is not based upon inadequate documentation to support the "gross-up". This issue could not come into play because the Intermediary's denial is strictly based upon lack of approval. The Intermediary made no attempt to review any of the calculations or documentation to support the "gross-up".

INTERMEDIARIES' CONTENTIONS:

The Intermediaries contend that it is cognizant of the fact that the HCFA Administrator has declined to render any decisions regarding those PRRB decisions cited in the Providers' preliminary position paper. The lead Intermediary is therefore considering those PRRB decisions to not apply to the prior approval requirement in HCFA Pub. 15-1 § 2314.B in order to settle or administratively resolve this group appeal. The Intermediaries, however, have not audited the statistics that supported the participating Providers' "grossing-up" methodology. As agreed in that regard, the Providers representative will furnish the related documentation that supports the participating Providers' grossing-up methodology to the designated Intermediary.

At this time, the Intermediaries note that it does not have a sufficient basis on which to allow the grossing-up method to allocate indirect costs to the drugs charged to patients cost center.

Therefore, pending the designated Intermediary's further determination in that regard, the Intermediaries contend as follows:

- The Providers has not yet demonstrated with compelling and convincing evidence the accuracy and propriety of the statistics that supported the participating Providers' "gross-up" methodology. At this time, the participating Providers are not in compliance with their record keeping responsibilities under 42 C.F.R. §§ 413.20 and 413.24, and HCFA Pub 15-1 §§ 2300, 2304 and 2404.2. The referenced Medicare Program regulations and instructions explicitly require participating providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare Program. Such data must be consistent with their financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited, and in sufficient detail to accomplish the intended purpose.

- In general, the fiscal Intermediaries' determinations or adjustments were not arbitrary and capricious as they were consistent with the referenced Program regulations and instructions. As such, contingent upon the result of the designated Intermediary's further determination, the Board should uphold the referenced Program regulations and instructions that supported the disputed determinations or adjustments, pursuant 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. 405.1867 and HCFA Pub. 15-1 § 2924.6.

CITATION OF PROGRAM LAW, REGULATIONS AND INSTRUCTIONS:

1. Law-42 U.S.C:

§ 1395x(v)(1)(A)	-	Reasonable Cost.

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1867	-	Sources of Board Authority
§ 413.5(a)	-	Cost Reimbursement: General
§ 413.9(b)	-	Cost Related to Patient Care
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding

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

§ 2300	-	Adequate Cost Data and Cost Finding
§ 2304	-	Adequacy of Cost Information
§ 2314, et seq.	-	Limitation of Allocation of Indirect Costs Where Ancillary Services Are Furnished Under Agreement.
§ 2404.2	-	Examination of Pertinent Data and Information
§ 2924.6	-	Scope of Board's Authority

4. Case Law:

Florida Life Care, Inc. Group-"Gross up" v. Ætna Life Insurance Company, PRRB Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide ("CCH") ¶ 38,522, declined review HCFA Administrator , June 14, 1990.

Sunbelt Health Care Centers Group Appeal v. Ætena Life Insurance Co., PRRB Dec. No. 97-D13, December 3, 1996, Medicare and Medicare Guide ("CCH") ¶ 44, 923, declined review HCFA Administrator, January 14, 1997.

Pinnacle Care Drug "Gross-Up" Group Appeal v. Ætna Life Insurance Co., PRRB Dec. No. 97-D41, March 26, 1997, Medicare & Medicaid Guide ("CCH") ¶ 45, 167, declined review, HCFA Administrator, May 6, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after reviewing the facts, parties' contentions, evidence, law, regulations and program instructions finds and concludes that the Intermediary improperly denied these Providers the opportunity to "gross-up" their non-Medicare costs and charges in order to allocate overhead costs and apportion appropriate costs to Medicare. The Board finds that the Providers' use of the "gross-up" method even without prior approval is consistent with 42 U.S.C § 1395x(v)(1)(A) and 42 C.F.R. § 413.5(a). Clearly, the "grossing-up" method results in a more accurate determination of Medicare reimbursement and helps prevent non-Medicare patients from bearing the cost of services that are undeniably attributable to Medicare patients. The Board finds that the Intermediaries' adjustments disallowing the Providers' use of the gross-up method result in a less accurate method of cost finding.

In Florida Life Care the provider argued that it should be permitted to use the grossing-up" method despite the absence of prior intermediary approval. In that case the Board agreed, stating:

> [c]learly, the "gross-up" method results in a more accurate cost findings approach. As such, it is consistent with the Medicare law and regulations. The Board does give great weight to, but is not bound by, the PRM. In this case, it finds the 90-day PRM limit for granting permission to use the "gross-up" technique is unreasonable because missing the 90-day deadline results in less accurate cost finding. This results in an improper underpayment of the Provider's costs and conflicts with 42 U.S.C § 1395 x(v) and 42 C.F.R. § 405.402.

Florida, (CCH) ¶ 38,522 at 22,946.

The Boards also finds that a letter written by HCFA, dated March 31, 1995, which is referenced in Sunbelt reinforces its decision to allow the Providers to use the gross-up method even though they did not obtain prior approval from the Intermediary. In part, that letter states:

> [t]he provider ignored a threshold requirement. . .by failing to obtain approval from the fiscal intermediary to use the direct assignment of costs. While we believe that this is an important requirement that should not be ignored by providers, our enforcement of this requirement has been reshaped by practical consideration. We have never been sustained on appeal in situations where failure to obtain prior approval is the only defect in a provider's use of a cost allocation alternative. The PRRB has adopted a "no harm, no foul" approach to enforcing this requirement. That is, as long as the provider's cost allocation alternative produces a more appropriate and more accurate allocation of cost, and is supported by adequate, auditable documentation, the provider's alternative has been accepted.

Id.

Based on this analysis, the Board finds that the Providers should have been allowed to use the "gross-up" method in 1993.

The Board also finds that three of the Providers filed their cost reports using the "gross-up" cost finding method while the remaining six Providers did not. The latter group proposed

using it during the Medicare Intermediaries' audit. The Intermediaries originally denied the approvals because they did not grant the Providers prior approval. Further, the Board finds that in its position paper the Intermediaries has introduced a new argument, i.e., the Providers did not provide adequate documentation to support the use of the gross-up method.

Based on these findings the Board concludes that the Intermediaries had the opportunity to review the documentation provided by the Providers but did not. It did so primarily because it disallowed the "gross-up" method because prior approval was not granted. The Board also finds that the Intermediaries made no attempt to review any of the calculations or documentation to support the "gross-up."[1] The Board finds in situations such as these that an intermediary is usually permitted to audit this type of information. Therefore, the Board will allow the designated Intermediary to review the available documentation submitted by the Providers to determine the appropriateness and correctness of the data to "gross-up" costs.

DECISION AND ORDER:

The Providers can "gross-up" its charges and costs even though it did not receive prior approval from the Intermediaries. The designated Intermediary may review the available Providers documentation to determine its appropiateness and accuracy. The Intermediaries adjustments are reversed subject to an acceptable audit of relevant documentation.

Board Members Participating:

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

Date of Decision: July 01, 1999

FOR THE BOARD

Irvin W. Kues
Chairman

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[1] See Provider Position Paper page 8.