PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D64

PROVIDER -
Chippewa Manor Nursing Home
Chippewa Falls, Wisconsin

Provider No. 52-5419

vs.

INTERMEDIARY -
Blue Cross & Blue Shield Association and Blue Cross and Blue Shield United of Wisconsin

DATE OF HEARING-
June 23, 1999

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 96-1263

INDEX

ISSUE:

Was the Intermediary's adjustment to apply the lower-of-costs or charges principle to the Provider's Part B cost of physical, occupational, and speech therapy properly applied?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Chippewa Manor Nursing Home ("Provider") is a skilled nursing facility ("SNF") located in Chippewa Falls, Wisconsin. The year at issue is the calendar year ended December 31, 1993, and the amount in dispute is approximately $47,000. For that year the Provider's Part B costs exceeded the Part B charges reported on the Medicare cost report. The Provider's Medicare fiscal intermediary, Blue Cross and Blue Shield United of Wisconsin ("Intermediary"), limited the Provider's reimbursement to the Provider's charges, based on Provider Reimbursement Manual ("Manual"), HCFA Pub. 15-1 ("HCFA 15-1") § 2600.

During 1993, the Provider furnished ancillary services (physical therapy, occupational therapy, speech therapy, medical equipment, medical supplies, and drugs) to the residents of the facility. The services were either furnished by the Provider or were provided by an independent contractor with whom the Provider had a contractual arrangement. In the case of therapy, services were provided to all residents. All residents that utilized these services were entitled to coverage under Medicare Part A or B. Therefore, no patient, insurance company or government program other than Medicare was liable for payment for any therapy services offered by the Provider. Consequently, the Provider billed only the Medicare program.

In the preparation of the 1993 Medicare cost report, Part B ancillary costs, which consisted primarily of therapy costs, were determined by the step down method of cost finding per HCFA Pub 15-1, § 2306.1. Those costs exceeded the reported ancillary charges. As a result, the fiscal Intermediary applied the lower of costs or charges principle under 42 C.F.R. § 413.13 (b) thereby limiting the Provider's reimbursement to its charges.

The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board"). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841. The Provider is represented by Joseph M. Lubarsky, CPA, of BDO Seidman, LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the issue in this case relates to whether it had an established charge structure for which patients were liable for payment on a charge basis during the cost reporting period. The parties do not dispute the fact that the Provider's ancillary costs exceeded its ancillary charges.

Likewise, 42 C.F.R. § 413.13 (b) and HCFA Pub. 15-1 § 2602 reimburse a provider the lower of reasonable cost or customary charges when patients are liable for payment under an established charge basis. However, relative to therapy services in this case, no patients were liable for payment on a charge basis; therefore, the lower of cost or charges limitation should not have been applied to those services.

The Provider notes that the Medicare statute requires that 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 will be responsible for reimbursing the reasonable cost of services attributable to its beneficiaries. It will not rely on other patients or payors 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 provision, the retroactive corrective adjustments requirement, obligates the Secretary to make such adjustments on a retroactive basis, i.e., looking backwards after the costs have been incurred and reported whenever the cost methods produce reimbursement that is less or more than reasonable costs. Obviously, this can result either in additional payments to a provider when the 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 Provider observes that although 42 C.F.R. § 413.13 and HCFA Pub 15-1, §§ 2600 and 2602 deal with the general principle and the application of the lower of cost or charges provision, § 2604.3 specifies what is considered a customary charge. It states: "[i]n order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of patients liable for payment on a charge basis." Id. If there are no patients liable for payment on a charge basis in a cost reporting period and the provider's customary charge cannot be determined through other means, then the lower of costs or charges principle will not be applied to this period. This Manual provision considers a patient to be liable on a charge basis if the patient is not entitled to coverage under Medicare Part A or Part B or other governmental program such as Medicaid. In such a situation, the application of the lower of costs or charges principle will effectively underreimburse a provider.

The Provider observes that the issue presented in this appeal has previously been resolved by the Board in a provider's favor. See Ballashire Hall, Inc. d/b/a Canterbury Care Center v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 97-D23, January 29, 1997, Medicare and Medicaid Guide (CCH) ¶45,063 ("Canterbury Care Center"). In that case, the provider did not have patients in its Medicare unit for which there was an established charge structure or from whom they were collecting revenue. Therefore, no lower of cost or charges limitation was applied. In addition to the Board decision, the issue in this appeal is identical to that resolved in Intermediary Hearing Decision, Robings Manor v. Ætna Life Insurance Company, March 10, 1988. In that case as in this one, there were no patients receiving therapy services on a charge basis; therefore,

no lower of cost or charges limitation was applied. There also have been no intervening developments that would warrant a different result in this case. Accordingly, the Board should hold that the Intermediary's application of the lower of costs or charges limitation is in error, and that the Intermediary must accept that the lower of costs or charges limitation is not applicable for the period in dispute.

The Provider observes that Canterbury Care Center was a freestanding SNF located in Crystal Lake, Illinois. The provider was licensed in March, 1989, and began participation in the Medicare program on April 19, 1989, filing an initial cost report for the period April 19, 1989, through December 31, 1989, using a charge of $94 per day. Upon audit, the intermediary utilized a customary charge of $250 per day thus enabling the provider to receive the actual costs of services under the lower of cost or charges methodology. However, the intermediary subsequently issued the Notice of Program Reimbursement adjusting its original determination and imposing a lower of cost or charges limitation based on a customary charge of $94 per day. The amount of $94 per day was used because that was the amount of the charge the provider used when it billed the Medicare program on the UB-82 billing form.

In Canterbury Care Center, the provider argued that it had no established customary charge for private pay patients receiving similar services as those provided to Medicare patients during the initial cost report. During 1989, there were no non-Medicare patients at the facility receiving nursing services similar to those that would be provided in the Medicare wing. However, there was one exception-- a Medicare patient whose rights were assigned to an Ohio HMO. The Provider did submit a claim to the HMO at a rate of $250 per day, but the claim was denied because there was an assignment of the patient's benefits to the HMO.

The provider argued that there was no evidence developed by the intermediary that determined the provider had an established charge schedule of $94 per day. In order for the intermediary to impose the lower of cost or charge principle, HCFA Pub. 15-1 § 2604.3 requires that the provider must have either an established charge schedule for like services or must have uniform, frequent, or typical charges which must actually be imposed uniformly on most patients and actually collected from a substantial percentage of patients liable for payment on a charge basis.

The fact of the matter that one patient received like services and the bill was never paid successfully supports that there was not a substantial percentage of patients liable for payment on a charge basis and billed at a uniform rate. These arguments included:

- There were no patients liable for payment on a charge basis during the year under review and the lower of cost or charges principle should not apply.

- HCFA Pub. 15-1 §§ 2602 and 2604.3 further support the contention that the lower of cost or charges principle is not

> applicable to the cost report under review. In HCFA Pub. 15-1, § 2604.3 charges are considered customary when they are uniform charges listed in a provider's established charge schedule and are actually imposed uniformly on most patients and are actually collected from a substantial percentage of patients liable for payment on a charge basis. Furthermore, HCFA Pub. 15-1 §§ 2604.3 B.1 defines "Patients liable for payment on a charge basis." It states that: Individuals eligible for coverage under Titles V, XVIII, or XIX of the Social Security Act, or local welfare programs are not subject to payment on a reasonable charge basis. Finally, HCFA Pub. 15-1 § 2604.3B states further that "[i]f there are no patients liable for payment on a charge basis in a cost reporting period and the provider's customary charges cannot be determined through other means, then the lower of costs or charges principle will not be applied to this period." Id.

The Provider observed that in ruling in Canterbury Care Center's favor, the Board found that there were not enough patients being charged in the Medicare unit to establish a customary pattern. No regular rate was charged to both Medicare beneficiaries and regular patients. Not only were there not enough patient charges, but there was no consistent pattern for charging those patients. Under the Medicare regulations charges are defined at 42 C.F.R. § 413.53(b)(2) [sic] as the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

The Provider notes that HCFA Administrator subsequently reviewed the Board's decision and concurred. The Administrator found the Board's decision to be reasonable and consistent with the governing laws, regulations and HCFA Pub. 15-1§ 2604.3. Furthermore, the Administrator supported the Board's findings that the Provider did not have a "customary charge" within the scope of the regulation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's methodology does not properly reimburse reasonable costs as required under 42 U.S.C. §1395x(v)(1)(A). The Intermediary observes that the Provider contends that it should not be subject to the lower of cost or charge limit for the therapy services since it does not have a proper customary charge amount. It should be noted that the excess of costs over charges relates entirely to the physical therapy department; therefore, this is the only department which will be discussed.

The Intermediary argues that although the Provider may not have a customary charge amount for the physical therapy department, only a reasonable cost amount can be claimed under the above law. This section of the law defines reasonable cost as the cost of any services actually incurred, excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services. In order to determine the efficiency as required by the law, it was necessary to obtain an average cost per unit and compare this amount to other similar facilities. The average cost per unit for the Provider was calculated as follows:

- The number of units was obtained from the Provider Statistical and Reimbursement Report ("PS&R"). Per this report, the Provider had 918 total units for the physical therapy department during 1993.

- These total units were then divided into the total physical therapy cost as shown on Worksheet C of the Medicare cost report. The calculated cost per unit was found to be $126 per unit.[1]

In determining the reasonableness of the Provider's cost per unit, a comparison was made with several other nursing home facilities in the state. Upon review, it was determined that the Provider's amount was excessive. The only provider with a similar cost per unit was subjected to the lower or cost or charges limit upon finalization.[2] Based upon this review, by not subjecting the Provider to the lower of cost or charge limitation, it would receive excess reimbursement. Therefore, the Intermediary was correct in applying this limit.

The Intermediary further argues that the Provider did not meet all of the provision of PRM 15- 1 § 2604.3. The Provider is using PRM 15- 1, § 2604.3 as a basis for not applying the lower of cost or charge limitations. This section states:

> If there are no patients liable for payment on a charge basis...in a cost reporting period and the provider's customary charge cannot be determined through other means, then the lower of cost or charges principle will not be applied to this period.

Id. (Emphasis added).

Although the Provider did not charge other than Medicare patients for these services, the determination of a reasonable rate would not have been difficult to find by determining what other outside services

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[1] See Intermediary Exhibit 1.

[2] See Intermediary Exhibit 2.

charge for a similar service. To simply claim costs without an effort to determine a reasonable customary charge is not acceptable.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C:

§1395x(v)(1)(A)	-	Reasonable Cost

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

§§405.1835-.1841	-	Board Jurisdiction
§413.5 (a)	-	Cost Reimbursement-General
§ 413.9 (b)	-	Definitions - Reasonable Costs
§ 413.13, et seq.	-	Amount of Payment If Customary Charges For Services Furnished Are Less Than Reasonable Costs

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

§2306.1	-	Step - Down Method
§2600	-	Principle
§2602	-	Application
§2604.3, et seq.	-	Customary Charges

4. Case Law:

Ballashire Hall, Inc. d/b/a Canterbury Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 97-D23, January 29, 1997, Medicare and Medicaid Guide (CCH) ¶45,063.

Robings Manor v. Ætna Life Insurance Company, March 10, 1988.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions and evidence finds and concludes that the Intermediary improperly applied the lower of costs or charges regulation and program instruction to the Provider's ancillary Part B costs. The Intermediary argues that the cost per service is unreasonable and presents a one page listing of four providers to show that the Provider's costs are substantially "out of line" per 42 C.F.R. § 413.9. The Board finds this evidence unconvincing. The Intermediary does not explain what type of costs are incurred. It lists physical therapy units but does not define a "unit." The Board has no basis to determine the appropropriateness of the study. Since the Intermediary must present a rebuttable presumption of evidence regarding "out of line" determinations, the Board concludes that the evidence submitted does not meet this burden.

The Intermediary cites HCFA Pub. 15-1 §2604.3 to support its adjustment of applying the lower of costs or charges to the Provider's Part B ancillary costs. Specifically, it cites the portion of the Manual provision which states that if a provider does not have a "customary charge", then "other means" can be employed to determine such a charge. The Intermediary argues that a reasonable rate would not have been difficult to find (by the Provider) by comparing their average charge to what outside contractors charge for similar services.

The Board reads this section differently. It reads it to mean that taken as a whole, if a provider has no patients liable on a charge basis, and the provider is unable to determine a reasonable customary charge through other means, then the lower of cost or charges provision does not apply. Other means include "in-house " analysis and review. It does not mean that providers are required to survey other institutions for their reasonable, customary charges that may or may not be representative of the Provider's situation.

The Board finds that the Provider's application of HCFA Pub. 15-1 § 2604.3 is correct. Since it only had Medicare patients and had no other patients to bill, the rate per service used by the Provider was merely a charge used to apportion costs to Medicare. Finally, the Canterbury Care Center Board decision supports the Board's decision in this case.

DECISION AND ORDER:

Medicare's lower of cost or charges regulatory provision does not apply to the Provider's Part B therapy costs. The Intermediary's adjustment is reversed.

Board Members Participating:

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

Date of Decision: August 25, 1999

For the Board:

Irvin W. Kues
Chairman