PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D55

PROVIDER -
Maxicare, Incorporated
Deerfield Beach, Florida

Provider No. 10-7123

vs.

INTERMEDIARY -
Palmetto Government Benefits
Administrators

DATE OF HEARING-
May 3, 2000

Cost Reporting Period Ended -
May 31, 1995

CASE NO. 97-1810

INDEX

ISSUE:

Was the Intermediary=s adjustment to the Provider=s visit statistic proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maxicare, Inc. (AProvider@) is a freestanding home health agency located in Deerfield Beach, Florida. During its fiscal year ended May 31, 1995, the Provider reviewed the number of professional care visits it made to beneficiaries before billing the Medicare program. Based upon these reviews, the Provider identified a total of 549 visits that exceeded the number of visits established under a physician=s plan of care. The Provider did not bill Medicare for these excess visits and excluded them from the data used to prepare its Medicare cost report.[1]

Aetna Life Insurance Company (AIntermediary@)[2] reviewed the Provider=s cost report and found the excluded visits. The Intermediary also found that no adjustment had been made by the Provider to exclude the costs applicable to the excluded visits from the cost report. Because the Intermediary believed that including the costs of the excluded visits in the cost report while excluding the visits themselves would result in Medicare=s payment of non-billed visits, it made an adjustment adding the visits into the cost report.[3]

On September 26, 1996, the Intermediary issued a Notice of Program Reimbursement reflecting its adjustment to the Provider=s visit statistic. On March 20, 1997, the Provider appealed the Intermediary=s adjustment to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $29,239.

The Provider was represented by Joanne B. Erde, P.A., of Broad and Cassel. The Intermediary was represented by Bernard M. Talbert, Associate Counsel, Blue Cross and Blue Shield Association.

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1 Provider Position Paper at 8.

2 Aetna Life Insurance Company withdrew from the Medicare Program in 1966, and Palmetto Government Benefits Administrators became the Provider=s Intermediary.

3 Intermediary Position Paper at 2.

PROVIDER=S CONTENTIONS:

The Provider contends that the Board previously addressed this issue and found that the Intermediary=s adjustment is improper. The Provider cites Visiting Nursing Association of Western New York, Inc. v. Blue Cross and Blue Shield Association, Blue Cross of Western New York/Empire Blue Cross, PRRB Dec. No. 91-D23, February 6, 1991, Medicare and Medicaid Guide (CCH) & 39077, decl=d rev. HCFA Administrator, March 26, 1991 (AVisiting Nursing Association of Western New York@), where the Board found that Aonly billable visits should be included in the visit count.@ The Provider asserts that this is clearly the circumstance of the instant case.[4]

The Provider also contends that it acted prudently when identifying the 549 subject visits and that it was proper to deem the visits Anon-billable.@

The Provider asserts that pursuant to 42 C.F.R. ' 484 et seq., a home health agency is required to render care pursuant to a physician=s plan of care. Moreover, the plan of care is to be strictly followed. Accordingly, the Provider maintains that it was required to conduct the internal quality control checks which identified the 549 excess visits.

With respect to the visits being non-billable, the Provider refers to the Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1") ' 2302.15, which defines a home health visit as follows:

> [a] personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health care worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospital, skilled nursing facility, rehabilitation center, or outpatient department . . .

HCFA Pub. 15-1 ' 2302.15 (emphasis added).

The Provider asserts that since the subject visits were not within the prescript of a physician=s plan they cannot possibly be a covered service. Thus, the Provider argues that it was correct in not claiming the visits and, conversely, the Intermediary is incorrect for including them in the Medicare reimbursement computation.

Concluding, the Provider maintains that it should be paid by Medicare for the costs of the professional staff=s Aadministrative@ time because Medicare was not billed for the 549 self disallowed visits.

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[4] Provider Position Paper at 9. Exhibit P-4.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment, which added the subject visits to the Provider=s Medicare cost report visit statistic, is proper.[5]

The Intermediary asserts that there are three types of visits not billed to the Medicare program, and each requires a specific treatment on the cost report to properly adhere to Medicare regulations.[6] The three types of visits along with their proper treatment are as follows:

(1) If the Provider goes to the patient's home and does not actually perform a service related to hands-on personal care due to the patient not being home or the patient's refusal of treatment, the visit should not be counted and any cost associated with the visit is allowable as an administrative cost. It is not counted as a visit since it does not meet the definition of a covered visit under 42 C.F.R ' 409.45. The cost associated with the visit is considered a common cost of doing business and is allowable in accordance with 42 C.F.R ' 413.9.

(2) If the Provider provides a service for the patient that does not meet the criteria established under 42 C.F.R ' 409.45, the Program considers the visit non-covered. The visit should not be counted; however, the cost associated with the visit must be included in a nonreimbursable cost center. Examples of non-covered visits are full-time home health aide services, custodial care, personal care aide, homemaker or home attendant services.

(3) If the Provider performs a service to a Non-Medicare patient that is considered to be a Alike kind@ visit, the visit should be included in the count and the costs associated with the visit should be included in the reimbursable cost centers. A Alike kind@ visit entails a visit that meets the criteria under 42 C.F.R ' 409.45; however, the patient is not insured under the Medicare Program. By ensuring the type and cost of services are comparable, Medicare will be paying its fair share of home health services when calculating Medicare's portion of cost under 42 C.F.R ' 413.53(a)(3).

Respectively, the Intermediary agrees that the services furnished by the Provider during the subject visits were not billable to Medicare. However, the Intermediary asserts that that fact alone does not qualify the visits for treatment as type (1) described above, where the visit is not counted but the costs are allowed as administrative costs. Rather, the Intermediary explains that the deciding factor is whether the

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[5] Intermediary Position Paper at 2.

[6] Intermediary Position Paper at 3.

Provider performed an actual service to the patient, and if so, were the services performed considered to be like kind?

With respect to this matter, the Intermediary asserts that its audit of the 549 non-billed visits disclosed the following four situations:[7]

(1) There were signed itineraries by the patient indicating that a visit was performed. No notes were in the patient's file.

(2) There were signed itineraries by the patient indicating that a visit was performed. There were notes in the patient's file.

(3) Signed itineraries, but the supervisor indicated that the visit would not be charged. No notes were in the patient's file.

(4) Signed itineraries, but employees were not scheduled to perform the visit. No notes were in the patient's file.

Based upon these findings, the Intermediary maintains that the Provider performed patient care services during the 549 subject visits; therefore, they are precluded from being considered Aadministrative@ in nature. In conclusion, the visits must either be counted or their costs placed in a non-reimbursable cost center for proper treatment under Medicare rules.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

'' 405.1835.-1841	-	Board Jurisdiction
' 409.45	-	Dependent Services Requirements
' 409.48(c)	-	Definition of Visit
' 413.9	-	Cost related to Patient Care
' 413.53(a)(3)	-	Determination of Cost of Services to Beneficiaries, Cost Per Visit by Type of

[7] Exhibit I-3.

Service Method-HHAs

' 484 et seq. - Conditions of Participation: Home Health Agencies

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

' 2302.15 - Definitions: Home Health Visit

3. Case Law:

Visiting Nursing Association of Western New York, Inc. v. Blue Cross and Blue Shield Association, Blue Cross of Western New York/Empire Blue Cross, PRRB Dec. No. 91-D23, February 6, 1991, Medicare and Medicaid Guide (CCH) & 39077, decl=d rev. HCFA Administrator, March 26, 1991.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, and evidence presented, finds and concludes as follows:

The Provider utilized a process whereby it reviewed the number visits made to a Medicare beneficiary before a claim for payment was submitted to the Intermediary. Based upon these reviews, the Provider self-disallowed 549 visits because they exceeded the number of visits prescribed in a physician=s plan of care. The Provider concluded, however, that the 549 visits were not to be treated as visits for the purpose of Medicare cost reporting because no Acovered service@ was performed. In reaching this decision, the Provider relied upon the definition of a home health visit found at HCFA Pub. 15-1 ' 2302.15, which states:

> Home Health Visit.B A personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health care worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a homebound patient on an outpatient basis to a hospital, skilled nursing facility, rehabilitation center, or outpatient department . . .

HCFA Pub. 15-1 ' 2302.15 (emphasis added).

Essentially, the Provider concluded that because the visits were outside of a physician=s plan of care

they were not reimbursable by the program and, therefore, not a covered service.

The Board finds, however, that the Provider=s conclusion is incorrect. A more complete reading of HCFA Pub. 15-1 ' 2302.15, or the pertinent regulation at 42 C.F.R. ' 409.48(c), explains that it is not necessary for an episode of personal contact with a patient to be reimbursable in order to be judged a visit. Rather, it is only required that the reason for the episode be for the purpose of providing a covered service as stated in the quoted rule above. Respectively, the Board finds that the purpose of the subject 549 episodes of personal contact was clearly to provide a covered service; notably, the Provider does not dispute that health care services were performed, but rather that they could not bill for the services since they were not within a physician=s plan of care. Moreover, the Intermediary=s audit disclosed itineraries signed by the patients indicating that visits were performed.

The Board, having concluded that the 549 episodes of patient contact at issue are in fact Avisits,@ further finds that they must be included in the Provider=s cost report visit statistic pursuant to 42 C.F.R. ' 413.53(a)(3). In pertinent part, the regulation states:

> Cost per visit by type-of-service methodCHHAs. For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service.

42 C.F.R. ' 413.53(a)(3) (emphasis added).

The Board notes that the cost of the 549 visits were included in the Provider=s cost report as administrative expenses.

Finally, the Board rejects the Provider=s reliance upon the decision rendered in Visiting Nursing Association of Western New York. If read in its entirety, that decision explains that certain visits were not to be included in the provider=s cost report because there was no hands-on patient care. In all, the Board in that case found that the provider was generally unable to complete the visits because the patients were not at home. Clearly, the visits at issue in Visiting Nursing Association of Western New York are distinguishable from the visits at issue in the instant case where health care services were furnished to Medicare beneficiaries.

DECISION AND ORDER:

The Intermediary properly included the Provider=s self-disallowed home health visits in the Medicare cost report visit statistic. The Intermediary=s adjustment is confirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq.
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman