PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D83

PROVIDER -
Brae Loch Manor Health Care Facility et al,
Rochester, NY

Provider Nos. Various

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Empire Medical Services

DATE OF HEARING-
March 7, 2000

Cost Reporting Periods Ended -
Various

CASE NOs. Various

INDEX

ISSUE:

Was the Intermediary=s inclusion of maintenance treatments in the Providers= cost apportionment statistics for Medicare reimbursement proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

On March 7, 2000, a hearing was held before the Provider Reimbursement Review Board (ABoard@) covering twenty three cases for nine different skilled nursing facilities (AProviders@) operating in the State of New York. All of the Providers are all-inclusive rate providers in that they do not issue a separate charge for therapy services to either Medicare or non-Medicare patients. Those Providers and the applicable cases are as follows:

Brae Loch Manor,
Provider No. 33-5532
Case No. 96-0732 (FYE 12-31-93)
Case No. 97-0474 (FYE 12-31-94)

Elcor Nursing Home,
Provider No. 33-5053
Case No. 96-1390 (FYE 12-31-93)
Case No. 97-0948 (FYE 12-31-94)

Harding Nursing Home,
Provider No. 33-5585
Case No. 96-0928 (FYE 12-31-93)
Case No. 97-0368 (FYE 12-31-94)
Case No. 98-0232 (FYE 12-31-95)
Case No. 99-0956 (FYE 12-31-96)
Case No. 99-3844 (FYE 12-31-97)

Maplewood Nursing Home,
Provider No. 33-5572
Case No. 97-0957 (FYE 12-31-94)

Nor Loch Manor Health Care Facility,
Provider No. 33-5535,
Case No. 96-1396 (FYE 12-31-93)
Case No. 97-0972 (FYE 12-31-94
Case No. 98-0705 (FYE 12-31-95)
Case No. 98-3073 (FYE 12-31-96)

Nortonian Nursing Home,
Provider No. 33-5439,
Case No. 97-0979 (FYE 12-31-94)
Case No. 98-0025 (FYE 12-31-95)

Palatine Nursing Home,
Provider No. 33-5685
Case No. 97-1197 (FYE 12-31-94)
Case No. 99-1117 (FYE 12-31-96)

Pontiac Nursing Home,
Provider No. 33-5590
Case No. 96-0862 (FYE 12-31-93)

Sunset Nursing Home,
Provider No. 33-5587,
Case No. 96-1641 (FYE 12-31-93)
Case No. 97-0499 (FYE 12-31-94)
Case No. 98-0316 (FYE 12-31-95)
Case No. 99-0753 (FYE 12-31-96)

Withe regard to the 1993 Medicare cost reports, the Providers opted to Aself-disallow@ all maintenance therapy program costs in that the Intermediary had maintained a policy of disallowing routine therapy costs.[1] However, in January 1995, prior to final settlement of the 1993 Medicare cost reports, the Providers filed amended 1993 cost reports claiming that the reimbursement methodology in Fenton Park Nursing Home v. Blue Cross and Blue Shield Association/Empire Blue Cross, PRRB Dec. No. 94-D6, December 30, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,051, decl=d rev. HCFA Admin. February 9, 1994 was applicable to the 1993 years at hand. In addition, the Medicare cost reports for all subsequent years were prepared in accordance with the Fenton Park reimbursement methodology.

The Intermediary did not accept the amended 1993 costs reports and continued to use the original 1993 cost report as the basis for issuance of the Notice of Program Reimbursement (ANPR@).[2] With regard to all subsequent years, the Intermediary issued Notices of Program Reimbursement (ANPRs@)

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[1] Provider Post Hearing Brief at p. 7.

[2] Id. at Exhibit P-6.

wherein the Intermediary readjusted the Providers= reimbursement for routine restorative and maintenance therapy costs. The Providers= Medicare cost reports were filed without maintenance treatments in the denominator of the apportionment ratios on Worksheet C. Upon review, the Intermediary increased the reported statistic to include maintenance treatments.

All Providers filed appeals challenging the Intermediary=s methodology in settling their cost reports. The Intermediary questioned the Board=s assumption of jurisdiction for the 1993 year appeals asserting that the Providers had either failed to file their appeals within the 180-day statutory time frame, or were alleging claims over an issue in which the Intermediary had made no determination. The Board considered the Intermediary=s jurisdictional objections and ruled that it did have jurisdiction over the 1993 Medicare cost report years.[3] Accordingly, the jurisdictional requirements as set forth in 42 C.F.R. ''405.1835.-1841 have been met.

On July 13, 1999 the Providers and the Intermediary proposed that the Board hear concurrently all sixteen (16) of the individual appeals identified at the time as involving the identical issue surrounding the Intermediary=s final cost report determinations.[4] The cases identified also included appeals for which neither party had filed a position paper at the time. The joint proposal also indicated that both parties would rely on a single, consolidated position paper in view of the number of cases involved. In addition, it was agreed that the single paper would also serve as the final position paper for any case wherein a position paper had not as yet been filed at the time of the Board=s approval. The Board concurred with the proposal on July 15, 1999.[5] Between that date and the present, seven (7) additional cases involving subsequent cost report years, but the same Providers, have been added.

The Medicare reimbursement effect in dispute is approximately $1,300,000. The Intermediary was represented by Eileen Bradley, Esq. of the Blue Cross & Blue Shield Association. The Providers were represented by Ross P. Lanzafame, Esq., and Jeffrey J. Calabrese, Esq., of Harter, Secrest & Emery, LLP.

PROVIDERS CONTENTIONS:

The Providers contend that the logic and principles enunciated by the Board in Fenton Park should apply in the cases at hand to serve as the appropriate apportionment methodology to apportion therapy costs to the Medicare program. Although the Intermediary has applied the Fenton Park methodology to charge-based providers, it has refused to apply the same methodology to the all-inclusive Providers

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[3] Id. at Exhibit P-3.

[4] Intermediary Position Paper I-2. (None of the Providers operate under common ownership or control, thus the group appeal mandate is not applicable).

[5] Intermediary Position Paper I-3.

in this appeal. Accordingly, the costs of maintenance and routine restorative therapy have been shifted to non-Medicare payors, and the Medicare program is not picking up its share of these proper indirect costs of a skilled nursing facility=s therapy department.

The Providers contend that the parallels between their case and the fee-for-service provider in Fenton Park are both obvious and compelling. First, as was the case in Fenton Park, the Intermediary=s practice of including maintenance statistics in total statistics on Worksheet C of the cost report results in costs being applied inequitably among Medicare and non-Medicare patients for all-inclusive providers.

Second, as in Fenton Park, the Providers do not charge non-Medicare patients a separate charge for maintenance and routine therapy treatments and can not bill Part A for such services. However, because the Intermediary refuses to include maintenance therapy costs as an indirect overhead expense reimbursed by Medicare, non-Medicare patients are forced to bear in their per diem payment rate the full cost of all maintenance therapy costs provided by the Providers; even those that are provided to Medicare patients.

Third, as in Fenton Park, the Intermediary=s maintenance therapy methodology for all-inclusive providers is not supported by any regulation or manual provision. In Fenton Park, the intermediary imputed charges for maintenance treatments on Worksheet C but did not include all charges on Worksheets D and E. The Intermediary applied the same incorrect methodology in this case by adding maintenance treatments on Worksheet C but not on worksheet D. Thus, the methodology is inconsistent and results in cost shifting to other payors.

Fourth, as the Board concluded in Fenton Park, in determining reasonable costs incurred by a Medicare provider, both direct and indirect costs must be taken into account as per 42 C.F.R. ' 413.9(b)(1). The Providers contend that this provision should be applied to all-inclusive providers as well as to fee-for-service providers.

The Providers also contend that testimony at the hearing established that:

1. Maintenance and restorative therapy costs were all audited by the Intermediary via a desk review or field audit for each year in question.[6]

2. With minor adjustments, all of the costs were accepted by the Intermediary as proper.[7]

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[6] Tr. at pages 63, 80, 157-160.

[7] Tr. At pages 245-246.

3. The Intermediary previously determined the therapy costs were properly allocated to and reported in the Therapy (Ancillary) cost center on the Providers= cost reports.[8]

Thus, absent any showing that the Providers= costs are unnecessary to the efficient delivery of covered services, the Intermediary=s refusal to reimburse maintenance and routine therapy costs in accordance with the principles of Fenton Park is in violation of the Medicare Act (42 U.S.C. '1395x(v)(1)(A).

The Providers further contend that the reported therapy costs meet the requirements of HCFA Pub. 12 ' 230.3(A)(2)(d), which allows the costs of routine restorative and maintenance therapy services to be properly included in the Therapy cost center, and billed as ancillary therapy services.[9] Testimony offered at the hearing[10] satisfied the above cited requirement in that:

(1) The therapy services were medically necessary.

(2) The therapy service treatments furnished were prescribed by a physician.

(3) All services were provided by salaried employees of the physical therapy department of the Providers.

(4) The costs incurred were reasonable in amount (i.e., the employees= salaries were reasonably related to the level of skill and experience required to perform the services in question); and

(5) As all-inclusive providers, charges were equally imposed on all patients.

The Providers also assert that the Intermediary=s new argument which advocates reallocation of the therapy costs from the Ancillary to the Routine cost center is without merit. HCFA Pub. 15-1 ' 2203.2 provides that costs may be considered ancillary in a skilled nursing facility and properly reported in the Ancillary cost center if the items and services provided are:

1. Directly identifiable services provided to individual patients;

2. Furnished at the direction of a physician because of specific medical needs and

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[8] Id.

[9] Tr. at pages 73-77

[10] Tr. at pages 74-76, 80, 175.

3. One of the following:

- not reusable
- represent a cost for each service
- complex medical equipment

A typical ancillary item would be the costs associated with therapy services, including physical, occupational or speech therapy services.[11] This is in contrast to HCFA Pub. 15-1 ' 2203.1 which indicates that costs are routinely reported in the Routine Cost Center if they are routinely and uniformly provided to all residents.[12]

This proposed methodology improperly places therapy costs in the Routine Cost Center where they are subject to the routine cost ceiling. Since the Providers= routine costs were established based upon costs that do not include the therapy costs, Medicare pays no portion of the Providers= maintenance costs, or only pays a fraction of these costs up to the routine cost limit amounts. This proposed approach serves only to effectively disallow the therapy costs at issue and shift them to other non-Medicare payors. It is also important to note that the Intermediary=s witness was unable to cite what instruction from HCFA would support the Intermediary=s proposal to place the costs at issue in the Routine Cost Center.[13]

The Providers point out that the Intermediary=s reliance on the Board=s decision in California Special Care Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D18, January 14, 1998, Medicare & Medicaid Guide (CCH) & 46,007, decl=d. rev. HCFA Admin. March 4, 1998, to support this new approach is misplaced. The key issue in California Special Care Center was whether the restorative nursing aide costs were properly classified as routine or ancillary costs. The Board determined that the aide cost failed to qualify as ancillary costs because the fifth criteria of HCFA Pub. 1 ' 230.3(A)(2)(d) was not met i.e. charges were not equally imposed on all patients.

The Providers= witness testified at the hearing as to several distinctions between California Special Care Center and the instant case. First, the fifth criterion cited above is met in the instant case as the Providers are all-inclusive rate Providers and their charges are, by definition, equally imposed on all patients.[14] Second, the Providers= therapy aides perform only therapy services, under the supervision of licensed therapists. This is in contrast to the aides in California Special Care Center , who also

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[11] Providers= Post Hearing Brief at P-11.

[12] Id.

[13] Tr. at p. 210-211.

[14] Tr. at p. 80-82

performed routine nursing services.[15] Finally, the Providers are required by New York State law to report therapy aides in the Therapy Cost Center.

INTERMEDIARY=S CONTENTIONS:

Initially, the Intermediary contended that the cost reports should be settled by employing a methodology which increased the reported statistics to include maintenance treatments. This served to lower the Provider=s average cost per treatment.

The Intermediary now contends in its final position paper and through testimony at the hearing that the proper methodology for handling maintenance therapy costs is to reprocess all the applicable cost reports. Maintenance costs and treatments are removed from Worksheet C and are placed in routine costs on Worksheet D-1.[16]

The Intermediary contends that the services at issue Amaintenance therapy services@ are by definition different from the types of therapy services normally reimbursed through the Ancillary Cost Center. The Ancillary Cost Centers are to take account of reimbursement exclusively for Arestorative services@ as they are defined in HCFA Pub. 12, Section 230.3(A)(2)(d).[17] The Intermediary argues that since only restorative services may appear in the Ancillary Cost Center, any reimbursement of allowable maintenance therapy services must occur through another cost report vehicle, i.e., the Routine Cost Center.

The Intermediary further contends that the Providers do not meet the requirements of HCFA Pub. 12 ' 230.3(A)(2)(d) which is an exception that provides for maintenance therapy costs to be included in Worksheet C of the cost report and reimbursed on the ratio of Medicare cost to charges. That section requires the services to meet the following conditions:

1. The services are medically necessary.

2. The treatment furnished is prescribed by a physician.

3. All services are provided by salaried employees of the physical therapy department of the provider.

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15 Tr. at p. 82-93.

16 Intermediary Exhibit I-42.

17 Intermediary Exhibit I-35.

4. The cost incurred is reasonable in amount (i.e., the employees= salaries are reasonably related to the level of skill and experience required to perform the service in question), and

5. Charges are equally imposed on all patients.

The Intermediary contends that in the instant case the fourth requirement is not met, as the exact costs of providing restorative services is unknown for all of the Providers. Absent that information, the Intermediary position is to utilize weighted treatments to quantify maintenance therapy costs and then reclassify those costs into the routine cost center.

The Intermediary also contends that the Providers= reliance on Fenton Park is without merit as the Board in Fenton Park was faced with two alternatives and chose a methodology based on a set of facts and circumstances which are not applicable to the present case. The Intermediary maintains that this case was flawed as follows:

1. HCFA Pub.- 12 Section 230.3(A)(2)(d) has five conditions that must be met for routine maintenance treatments to be allowed as an ancillary service. In particular, the fifth requirement requires that charges are imposed equally on all patients. The next paragraph in the manual advises that if all conditions are met routine therapy services can be billed and reimbursed as part of a therapy cost center.The Intermediary contends that the Board has chosen to interpret this requirement to mean only the restorative treatments are equally charged, not all treatments (restorative and maintenance) as the charges that must be billed as per HCFA Pub. 15-1, Section 2203.

2. Part B is a supplemental insurance coverage that picks up certain types of medical services when a beneficiary=s primary coverage (Part A) runs out. Part B does not pay for room or board or any of the services routinely provided with room and board services. A routine maintenance treatment does not meet the reasonable and necessary test in HCFA Pub. 12, Section 230.3(A) (2)(d). By not meeting the definition of a valid therapy treatment, the Part B program cannot pay for that service (HCFA Pub. 12, Section 230.3(A)(2)(d) and HCFA Pub. 15-1, Section 2220.1). Routine maintenance therapy treatments can only be paid for as a routine service by any one of the primary payors (Medicare Part A, Medicaid and Private).

3. The Board decision allows a cost shifting from the primary payors (Part A, Medicaid and Private) to the Part B program. This cost shifting of routine costs to the Part B program (which does not pay routine services) is a violation of HCFA Pub. 15-1, Section 2200.1 which states in part that costs of a provider are apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries.

4. The decision is labeling routine maintenance treatments as indirect costs, i.e., A&G, as costs to be

allocated based on the total charges recorded in the therapy cost center. In reality, these are medical services to specific patients which, at a minimum, belong in routine patient services.

The Intermediary contends that since Fenton Park is not applicable to the case at hand, its revised position, as set forth above, is the appropriate way to reimburse maintenance therapy services. The Intermediary points to California Special Care Center. In that case, the Board held that the Intermediary was correct in reclassifying the salaries of restorative nursing aides from the physical therapy cost center to the routine cost center.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.

   ' 1395x(v)(1)(A) - Reasonable Costs

2. Regulations - 42 C.F.R.

   '' 1835-.1841 - Board Jurisdiction

   ' 413.9(b)(1) - Reasonable Cost

3. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1)

   ' 2200.1 - Principle of Cost Apportionment

   ' 2203 et. seq. - Provider Charge Structure as Basis for Apportionment

   ' 2220 - Part A Services Furnished by the Physical Therapy Department of a Hospital or Skilled Nursing Facility

   ' 2220.1 - Part B Outpatient Physical Therapy Provision

4. Program Instructions - Skilled Nursing Facility Manual (HCFA Pub.-12)

   ' 230.3(A)(2)(d) - Routine Services

5. Cases

Fenton Park Nursing Home v. Blue Cross and Blue Shield Association/Empire Blue Cross, PRRB Dec. No. 94-D6, December 30, 1993, Medicare & Medicaid Guide (CCH) & 42,051, decl=d. rev. HCFA Admin. February 9, 1994.

California Special Care Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D18, January 14, 1998, Medicare & Medicaid Guide (CCH) & 46,007, decl=d. rev. HCFA Admin. March 4, 1998.

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 the post hearing brief, finds and concludes as follows:

The Board finds, through testimony at the hearing, that the Intermediary has verified the claimed therapy costs and determined that they were reasonable in amount. The key issue before the Board is whether the therapy costs in question should be placed in the Routine Cost Center, as advocated by the Intermediary, or in the Ancillary Cost Center, as claimed by the Provider.

The Board finds that HCFA Pub. 15-1 ' 2203.2 provides that items and services (other than the types classified as routine services in ' 2203.1) may be considered ancillary in a skilled nursing facility if they are:

(1) Direct identifiable services to individual patients and

(2) Furnished at the direction of a physician because of specific medical needs and

(3) One of the following

- Not reusable

- Represent a cost for each service

- Complex medical equipment

The Board finds, in the instant case, that the maintenance and routine restorative services were primarily provided by therapy rehab aides, who were all employees of the various therapy departments. The services were ordered by physicians and were performed under the supervision of licensed therapists. Based on these factors, the Board concludes that the services were not provided across the board to

most residents. Rather, they are quite specific for each resident receiving service.

The Board also finds that HCFA Pub.12 ' 230.3(A)(2)(d) states that:

> [M]any 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 personnel, without supervision of a qualified physical therapist. Such services . . . can be reimbursed through the physical therapy cost center if:
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> * The services are medically necessary;
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> * The cost incurred is reasonable in amount; and
>
> *Charges are equally imposed on all patients.

The Board finds that the Intermediary=s argument that the Providers did not meet the criteria set forth above is without merit. Testimony offered at the hearing established that the Intermediary conducted desk reviews or audits of the Providers= costs, and determined that all costs were properly reported. None of the claimed costs were identified as being unnecessary to the efficient delivery of covered services. Further, the Intermediary witness testified that HCFA stated that the therapy costs at issue should be treated as Routine costs. However, that witness was not able to introduce any evidence into the record, such as a letter, directive or manual instruction to support the HCFA position. On the other hand, the Board notes that New York state law requires Providers to report therapy aides in the Therapy Cost Center.

The Board also notes that HCFA Pub. 15-1 ' 2220 lends additional support to the proposition that routine restorative services can be viewed as ancillary in nature. While this section deals with billing aspects, the stated criteria is similar to that of HCFA Pub. 15-1 ' 2203.2 and HCFA Pub.12 ' 230.3(A)(2)(d).

Based on the criteria cited above and the evidence in the record, the Board finds and concludes that the therapy costs in question should be properly reported in the Ancillary Cost Center. This is further supported by the Board=s previous decision in Fenton Park. In that case, the Board concluded that the costs of providing maintenance and routine restorative treatments for Medicare patients may not be shifted to other patients and payors. Also, the Board determined that the providers were entitled to reimbursement through the Medicare rate-setting formula for routine and maintenance therapy costs.

The Board finds that the Intermediary=s reliance on the California Special Care Center case to support its position for inclusion of therapy costs in the Routine Cost Center has several flaws. First, the aides in California Special Care Center performed other types of routine nursing services, whereas the aides in the instant case performed only therapy services. Additionally, unlike the aides in California Special Care Center, the Providers= therapy aides perform their duties under the direction of licensed therapists. Another distinguishing factor is that skilled nursing facilities in California have Adistinct parts@ (i.e. separate Medicare-certified units), whereas all of the beds in a New York state nursing facility are Medicare certified. The Board also notes that the Providers in this matter utilize an all-inclusive rate structure. In the absence of Adistinct parts@ in New York, the routine costs of a nursing facility in New York will be spread among all patients. Following the methodology of California Special Care Center and reallocating all maintenance and routine restorative services to the Routine Cost Center would not give proper recognition to the high utilization of care by the Providers= Medicare patients. As a result, the Medicare program would not pick up its fair share of the Providers= costs.

Having determined that the therapy costs are properly reportable as Ancillary costs, the Board finds that the cost reporting mechanism for an all-inclusive provider is applicable in this case, subject to modification. Specifically, on Worksheet C the cost per treatment should be determined by dividing total step-down cost by a denominator consisting of Arestorative@ treatments only.

The Board finds that the Intermediary proxy used to calculate the cost per treatment is not accurately measurable. In the instant case, the Intermediary applied the Medicare utilization factor to total maintenance visits to arrive at a weighted number of Medicare maintenance visits. That number was then added to the restorative visits and the resulting total of restorative/maintenance visits was used as the denominator. The Board finds that the testimony at the hearing indicated that total Medicare maintenance visits were not known, and are not a part of the record. Absent that information, the Board concludes that the most accurate methodology is to use a denominator of restorative treatments only in calculating the Providers= cost per treatment.

DECISION AND ORDER:

The Board finds that the Providers= maintenance therapy costs were properly included in the Ancillary cost center. The Intermediary=s inclusion of maintenance treatments in the Providers= cost apportionment statistics was improper. The Providers= cost per treatment should be calculated using only Arestorative@ treatments as the denominator.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire

Martin W. Hoover, Jr. Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 19, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman