PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D85

PROVIDER -
Sonoma Valley Hospital District
Sonoma, CA

Provider No. 05-0090

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association / Blue Cross of California

DATE OF HEARING-
July 26, 2000

Cost Reporting Period Ended -
June 30, 1994

CASE NO. 96-2085

INDEX

ISSUE:

Was the Intermediary=s calculation of the Skilled Nursing Facility (SNF) Routine Cost Limits (RCL) proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sonoma Valley Hospital District (Provider) is a general service, short term, acute care, non-profit hospital located in Sonoma, California. During FYE 6/30/94, it operated 64 acute care beds and 28 skilled nursing beds. The acute care beds were reimbursed under Medicare's Prospective Payment System (PPS) while the skilled nursing unit was reimbursed under the traditional Medicare cost reimbursement system. The Provider also offered a wide range of outpatient services including home health services. The Medicare inpatient utilization during the cost year was:

	PPS	SNF
Medicare Patient Days	6,732	7,574
Total Patient Days	10,770	8,365
Medicare Utilization	62.51%	90.54%.

The Provider submitted a request for an exception to the Skilled Nursing Facility (SNF) routine cost limit based upon atypical nursing costs, which is one of the circumstances for which a provider can request an exception to the SNF routine cost limitation, as outlined in 42 C.F.R. '413.30(f). The Intermediary granted an interim exception to the SNF RCL on May 31, 1995, for direct, employee benefits, administrative and general, nursing administration, and medical records costs. A final exception determination was issued on Nov. 20, 1996, incorporating the final Medicare cost report data from the NPR dated Jan. 19, 1996.

In both the interim and final SNF RCL exception requests, the Intermediary denied the Provider's request for an exception to the Social Service cost center based upon its determination that the Provider utilized an unacceptable Worksheet B-1 statistic for the allocation of social service costs. The Provider disagreed with the Intermediary's finding and filed an appeal with the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R '' 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount in contention is approximately $343,860.

The Provider was represented by Glenn S. Bunting of Toyon Associates Inc. The Intermediary was represented by Bernard M. Talbert Esq. of the Blue Cross Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider points out that both HCFA and the Intermediary agree that the type of patients and the patient care provided were atypical as compared to the average SNF population base from which HCFA derived

the routine cost limits. As part of the process of quantifying an exception amount HCFA requires (HCFA Pub. 15-1 ¶2534.5(B)) that a Provider's SNF costs be compared to the Uniform National Peer Group.

The Provider contends that in order to achieve a proper reclassification of its SNF costs for peer group purposes and align the Provider's SNF per diem costs with HCFA's peer group per diem costs, it is necessary to know the type or nature of the cost included in the construction of HCFA's peer group. A review of the Provider's final SNF exception finds that some questionable cost reclassifications have been incorporated. The Intermediary has failed to provide any documentation that would support the cost reclassifications utilized in the final SNF exception.

The Provider argues that the Intermediary's $49,311 cost reclassification of the nursing manager's salary from the direct cost center to the nursing administration cost center is contrary to HCFA Pub. 15-1 ¶2534.10(A) guidelines. In addition, this reclassification of cost for peer group comparability directly contradicts HCFA's policy regarding the treatment of the salary of nurse managers in processing SNF exception requests. This is according to a HCFA letter dated September 29, 1997 from the Deputy Director, Division of Post Acute Care.

If the position of nurse manager is synonymous with that of a head/charge nurse, Section 2534.10(A) of PRM 15-1, in general, specifies that this cost is a direct cost. If the charge nurse assigned to the unit, performs duties in the unit as opposed to departmental offices and does not function as a director of nursing, we believe the salary of the charge nurse should be considered a direct cost.[1]
The Provider contends that the nurse manager should be classified as "head/charge" nurse as defined above and should have been included in direct salary costs for purposes of the exception calculations.

The Provider contends that the Intermediary incorrectly calculated or quantified the Provider's atypical Social Service cost per diem. The Provider contends that the Worksheet B-1 cost allocation statistic (time spent), which it utilized to allocate Social Service costs, has been accepted by the Intermediary as the proper cost allocation statistic for years. HCFA Pub. 15-1 Section 2534 requires that SNF exception requests be quantified based upon the costs, both direct and indirect, reflected in the Provider's Medicare cost report. Specifically, HCFA Pub. 15-1 ¶2534(J) Atypical Social Service Cost states:

> An exception is granted based on a demonstrated lower than average length of stay and/or higher than average Medicare utilization. It is computed as the provider's social service per diem cost in excess of the peer group social service per diem cost.

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[1] See Exhibit P-3

The Intermediary states: Line 9 cannot be used because unacceptable Worksheet B-1 statistics were used.[2] The Provider maintains that the Intermediary's calculation of an exception for atypical SNF Social Service costs based upon the fact the Provider utilizes a cost finding statistic of Atime spent@ rather than the Intermediary's preferred statistic of patient days is incorrect. HCFA Pub. 15-1 '2534 does not allow an intermediary to deviate from the Worksheet B-1 statistics utilized in the Medicare cost report and utilize a different cost finding statistic for SNF exception purposes. The intermediary is required to utilize the SNF costs as audited in the final Medicare cost report for determination and quantification of a SNF exception amount. The Provider further contends that if the Intermediary is dissatisfied with the Social Service statistic of time spent, which has been the accepted statistic for years, the Intermediary should make a change to the Provider's Medicare cost report in order to reflect the change in the final SNF exception determination.

The Provider requested the Intermediary to revise their calculation of an exception for atypical Social Service costs from zero per day to $0.60 per day. This would be in accordance with HCFA Pub. 15-1, '2534(J) which quantifies an exception as the amount by which the Provider's actual Social Service cost per day exceed the peer group mean cost per day.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not demonstrate that it is entitled to an exception for the atypical social service costs or that the Intermediary's determination was inaccurate or erroneous and therefore unacceptable for cost reporting purposes. If inaccuracies exist, the Provider has the burden of proof to provide evidence of such errors. To date, the Provider has not furnished any supporting documentation.

The Intermediary contends that its determination was based on the best available data for purposes of: 1) apportioning allowable cost of services to beneficiaries, pursuant to 42 C.F.R. '413.50 and '413.53 determining program payments, pursuant to ' 1814(b) and ' 1815 of the Social Security Act (redesignated as 42 U.S.C. ''1395f(b) and 1395(g), 42 C.F.R. '413.24 and 42 C.F.R '413.53, and HCFA Pub. 15-1. chapter 24.

The Intermediary contends that due to insufficient documentation its determination was proper, and was made in accordance with Program regulations, instructions and guidelines.

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[2] See Exhibit P-2

CITATION OF LAW,REGULATIONS AND PROGRAM INSTRUCTIONS

1. Law-42 U.S.C..:

' 1395f(b)	-	Conditions of and Limitations on Payment for Services
' 1395(g)	-	Payments to Providers of Services

2. Regulations - 42 C.F.R.

'' 405.1835-.1841	-	Board Jurisdiction
' 413.24	-	Adequate Cost Data and Cost Finding
' 413.30(f)	-	Limitation on Reimbursable Cost
' 413.50	-	Apportionment of Allowable Costs
' 413.53	-	Determination of Cost of Services to Beneficiaries

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

' 2500	-	Limitation on Coverage of Costs Under Medicare and Notice of Schedules of Limits on Provider Costs
' 2534 et seq	-	Request for Exception to SNF Cost Limits

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 was given a portion of the atypical cost which they had requested. The Board also finds that there are actually two issues to be determined: one is the Atypical Social Service cost issue and the second is the Atypical Nursing Service cost issue.

With regard to the Atypical Social Service cost issue: The Board finds that the Provider used the Worksheet B-1 cost allocation statistic of Atime spent@, in prior years, as well as in the current cost report. The Intermediary accepted this method of cost allocation in the prior years. The Board finds that HCFA Pub. 15-1 '2534 requires that the Intermediary not deviate from the Worksheet B-1 statistic utilized in the Medicare cost report and use a different cost finding statistic for SNF exception purposes. Therefore, the

Board finds that the Provider was correct in using the recommended statistic. The Intermediary=s adjustment was not proper and should be reversed.

With regard to the second issue, the Atypical Nursing Service cost issue: The Board finds that the Provider did request information concerning the peer group from the Intermediary. However,the Provider did not make a motion to compel a discovery request to the Board for information concerning a peer group analysis. The Board also notes that the documentation supporting both parties contentions was not completely developed.

The Board notes that the Intermediary reclassified the nursing manager=s salary due to a lack of documentation. The Intermediary reclassified the nursing manager=s salary based on the job description. The Board notes that while the Provider challenged the reclassification, the record does not support the Provider=s argument.

The Board finds that it was proper for HCFA to use the peer group when it reviewed the Provider=s exception request in regard to the nursing cost. The Board finds that there is insufficient documentation in the record to support the Provider=s claim for additional nursing cost. Therefore, the Board affirms the Intermediary=s adjustment of the nursing cost.

DECISION AND ORDER:

The Intermediary=s adjustment concerning the cost of social services was not proper. The Intermediary=s adjustment is reversed.

The Intermediary=s adjustment concerning the reclassification of nursing cost was proper. The Intermediary=s adjustment is affirmed.

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 20, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman