PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D31

PROVIDER -
Rennes 97 Reclass Routine Rest Ther Aide Group

Provider No.: Various
(See Appendix A)

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ United Government Services

DATE OF HEARING-
November 15, 2000

Cost Reporting Period Ended -
December 31, 1997

CASE NO. 00-0573G

INDEX

ISSUES:

1. Was the Intermediary's reclassification of routine restorative therapy aide salaries from the physical therapy cost center to the SNF participating and non-participating cost centers proper?

2. Was the Intermediary's reclassification of the salary used for the employee health and welfare worksheet B-l overhead allocation basis proper?

FACTS:

The Rennes Group ("Providers") consists of four commonly owned Medicare skilled nursing facilities in Wisconsin. The four SNFs are: Rennes Health Center-Appleton, Rennes Health Center-DePere, Rennes Health Center- East, and Rennes Health Center-West.

In cost report year 1997, the Providers' patients received non-routine restorative therapy services on-site, through an outside group provider, Greenfield Rehabilitation Services, Inc. In addition, the Providers provided routine restorative therapy services to both program beneficiaries and non-beneficiaries through restorative aides, who were the Providers' own employees. The restorative aides received their instruction, oversight of patient care and day-to-day direction from the contract therapists. The contract therapists, subject to physician concurrence, also determined what type of routine restorative services would be provided to the residents and how those services would be provided. Each Provider had its own therapy department, which was physically removed from the nursing department within each building. The restorative aides did not provide general nursing services to patients, except in emergencies.

The charge structure of the Providers was as follows: All nursing home residents who were able to be charged, were charged routine restorative services. The costs of providing these services were reported in the physical therapy cost center. Private pay patients paid a room charge that was an average of $11 per day higher than the Medicare program paid, in addition to being separately charged for any routine restorative therapy services they may have received. The Medicaid program was not billed separately for routine therapy because of State law providing for an all-inclusive charge.

On August 17, 1999, United Government Services ("Intermediary") sent the Providers the unaudited Medicare cost settlements for the cost reporting year 1997. The settlement adjusted costs for restorative therapy costs in the ancillary cost center and reclassified those costs to each Provider's routine cost center.

The Intermediary has conceded that the routine restorative therapy services were medically necessary, that they were prescribed by a physician, that they were provided by salaried employees of the Providers, and the salaries of those employees were reasonably related to the level of skill and experience required for the tasks performed.
The two reasons that were given by the Intermediary for its reclassification of the 1997 costs

were: (1) The Providers' salaried employees were not supervised by the physical therapists and therefore they were not part of the physical therapy department and, (2) the charges were not imposed equally on all patients, because the charges to patients for the services were nominal. The Providers appealed the Intermediary's decision to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§1835-.1841 and have met the jurisdictional requirements of those regulations. The Medicare reimbursement in contention is approximately $153,000.00.

The Providers were represented by Robert M. Hesslink Jr., Esquire, of Hesslink Law Offices. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

ISSUE 1

PROVIDERS' CONTENTIONS:

The Providers contend that routine restorative therapy costs, which consist of the compensation of the restorative aides, should be included in the ancillary physical therapy cost center because routine restorative services are not routinely provided to all patients. These services are only given where they are specifically required in individual cases. In addition, the evidence shows that the five criteria specified in HCFA Pub. 15-1 §2220, for inclusion of such costs in an ancillary cost center, are met in this case. The Providers further contend that neither recent decisions nor long-standing Board authority supports the adjustments made by the Intermediary.

The Providers point out that in Fenton Park Nursing Home v. Blue Cross and Blue Shield Association/ Empire Blue Cross, PRRB Dec. No. 94-D6, Medicare and Medicaid Guide ("CCH") §42,051 December 30,1993, declined rev. HCFA Admin. February 9,1994, the Board concluded that both maintenance and routine restorative therapy costs were properly included in the physical therapy cost center so long as the requirements of HCFA Pub. 15-1 §2220 were met. The Provider further points out that in California Special Care Center (La Mesa Calif.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, PRRB Dec. No. 98-D18, Medicare and Medicaid Guide ("CCH") §46,007 Jan. 14, 1998, declined rev. HCFA Admin. March 4, 1998, the provider was denied the opportunity to include its restorative nursing aide costs in its PT ancillary cost center because the evidence established that it had not imposed such charges equally to all patients.

In California the only charges imposed for therapy services at all were those imposed for professional therapy services. The aides who provided the service also performed regular nursing assistant duties within the home. On that record the Board had to conclude that the equally imposed charge requirement was not met.

The Providers point out that in Brae Loch Manor Health Care Facility v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D83, Medicare and Medicaid Guide ("CCH") §80,568 Sept. 19, 2000, the Board held that twenty-three nursing homes were entitled to include

maintenance therapy costs in their ancillary therapy cost centers, even though they had not separately billed those costs to any payors. That case recognized the basic underlying difference between routine and ancillary services. The Board concluded that because the provider used an a11-inclusive charge structure, that rate structure itself resulted in the equal imposition of charges required by the California decision and HCFA Pub. 15-1 §2220. Id.

The Providers point out that in Brae Loch Manor Health Care Facility v. Blue Cross and Blue Shield Association/Empire Medicare Services, HCFA Administrator Decision, Medicare and Medicaid Guide ("CCH") § 80,622 Nov. 20, 2000, the Administrator reversed the Board. The Administrator disagreed with the Board that the provider's maintenance therapy services could properly be allocated to the ancillary cost center. The Administrator also decided that the Board did not have jurisdiction over the case. Since the Board did not have jurisdiction over the case, the Administrator also lacked jurisdiction over the issue concerning the maintenance therapy costs. Therefore, the Provider argues that as long as the Administrator's decision remains the law, the Board is required to review future cases as though Brae Loch had never happened.

The Providers contend that the Board has held that a provider may report the salaries of its restorative aides in a separate physical therapy cost center, rather than in its routine cost centers where five factors have been met. Those five factors are:

1. The services must be medically necessary;

2 Treatment must be prescribed by a physician;

3. Services must be performed by employees of the physical therapy department of the group provider;

4. The costs must be reasonable; and

5. Charges must be equally imposed.

The Providers argue that the Intermediary has conceded that items 1, 2 and 4 were met in this case. The testimony also shows that these services are not provided routinely, but only where they are medically required.

The Providers argue that the Intermediary is not correct in its contention that the Providers did not meet items 3 and 5 because the physical therapy aides were not supervised by the physical therapists, who work for an outside contract provider, and because the amounts charged to other payors for the therapy services are "nominal" thereby violating the "charges equally imposed" requirement.

The Providers contend that the restorative aides performed the services within the physical therapy department and under the supervision of the Physical therapists. In all matters, other than routine administrative matters such as scheduling of vacations, the restorative aides' work was

overseen by the therapists. The Providers point out that HCFA Pub. 15-1 § 2220(a) states:

> Provider will be considered as having a physical therapy cost center if the services it furnishes meet the above conditions even when the provider has a qualified physical therapist who works only a few hours per week or when the provider has no qualified physical therapist. . . . In other words, it is not necessary for a provider to have a qualified physical therapist or an actual physical therapy department to establish a physical therapy cost center.

Id.

Therefore the Providers contend that if a provider is not required to have a physical therapy department or physical therapist at all in order to have a physical therapy cost center, it is not required to have its restorative aides report to the physical therapist on routine administrative matters, such as scheduling vacations, as a condition for including their compensation in that cost center. It is the oversight of the delivery of the routine restorative services that is determinative.

The Providers point out that it established a physical therapy department, which was overseen by the contract therapists, at a separate location within each nursing home. The restorative aides were supervised by the therapists in the delivery of the services to the residents. The therapists oversaw the exact nature, frequency and quality of the routine restorative services that the restorative aides provided.

The Providers contend that the charges were equally imposed. The Providers charged all of its private pay patients for the routine services that it provided to them. It also booked a charge for the routine restorative services provided to Medicaid patients, though it was not permitted to collect that charge from Medicaid patients as a separate item. In the State of Wisconsin, Medicaid rates are required by law to be all-inclusive. The Providers charged and collected from everyone for its routine restorative services that, by law, it was able to. The Providers had separate restorative aides who provided this service out of a separate department, and these employees did not perform normal nursing assistance duties.

The Providers contend that under the Fenton Park methodology, once a provider has established that it meets the five conditions, including that its routine restorative therapy is a separately charged service for non-Medicare payors, the burden then shifts to the Intermediary to show that inclusion of the routine restorative therapy costs in the ancillary cost center would lead to an inequitable result to the Medicare program. The Providers contend that they met the five conditions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the issue in this case involves the use of charges as a statistic to

apportion costs of a given ancillary service to the Medicare Program. Such an apportionment can only be fair and accurate when there is a reasonably consistent relationship between the cost of a service and the associated charges. In this case the Provider is arguing that it is appropriate to have in one cost center a service that is priced with a normal profit margin and a second service priced at a deep discount.

The Intermediary points out that HCFA Pub. 15-1 §2220 states:

> Direct identifiable services furnished to program beneficiaries by the physical therapy department of a hospital or skilled nursing facility which do not require the skills of a physical therapist, although considered routine restorative nursing services, can be billed as ancillary services in order to establish an equitable basis for apportioning costs of the physical therapy cost center if the following conditions are met:
>
> 1. The services are medically necessary;
>
> 2. The treatment furnished is prescribed by a physician;
>
> 3. All services are provided by salaried employees (whether full-time or part-time) of the physical therapy department of the provider (if, on the other hand, the services are furnished under arrangements, the services would not be covered since under the law, routine restorative nursing services must be furnished by the provider directly, and cannot be covered if furnished under arrangements);
>
> 4. The cost incurred is reasonable in amount (i.e., the employees' salaries are reasonable related to the level of skill and experience required to perform the services in question); and
>
> 5. Charges are equally imposed on all patients.
>
> A provider will be considered as having a physical therapy cost center if the services it furnishes meet the above conditions even when the provider has a qualified physical therapist who works only a few hours per week or when the provider has no qualified physical therapist, e.g., that period of time between the periods of employment of a qualified physical therapist. In other words it is not necessary for a provider to have a qualified physical therapist or an actual physical therapy department to establish a physical therapy cost center. Charging practices will be evaluated to insure

> that an equitable basis for apportioning cost results.

Id.

The Intermediary contends that it is undisputed that the services provided by the routine restorative therapy aides are routine restorative services within the meaning of the above section. The requirements are imposed to allow the costs to remain in the physical therapy cost center only if charges are uniformly imposed on all patients and that the charges provide an equitable basis for apportioning costs as per 42 C.F.R. § 413.53 which states:

> Charges mean 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.

Id.

The Intermediary further argues that the apportionment methodology is stated as 42 C.F.R § 413.53(a)(I)(I):

> Except as provided in paragraph (a)(1)(ii) of this section with respect to the treatment of the private room cost differential for cost reporting periods starting on or after October 1, 1982, the ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department;

Id.

The Intermediary points out if we assume an ancillary department has one service that can reasonably be costed at $100, and another that can be reasonably costed at $10, and furnished 10 of each in a given period, if the respective charges are $200/20; $150/10 or $50/5, a fair apportionment will result. If the charges are not reasonably related to cost (say the $100 service is priced at $200 and the $10 service is priced at $5), then payors of the more expensive service are subsidizing the cost of the less expensive service. The charges are not a relative reflection of resource consumption. In this case, the Providers' charge structure and charging practices for the service it wants grouped in its PT cost center are substantially flawed as an equitable apportionment tool. The Intermediary points out that the current appeal covers the Providers' cost reports for the FYE December 31, 1997. The Intermediary's primary work up or factual analysis was done off of a Provider facility in the context of the review of 1996. The Intermediary concluded that its 1996 findings were sufficient to support similar treatment for the 1997 cost reports.

The Intermediary argues that it explained what was reviewed for 1996. The next step was to use

1997 data to show that the same problems existed in 1997 as 1996. The Intermediary contends that the Providers' presented no affirmative statistical evidence that criteria (inter alia, charges equally imposed, equitable charge structure) exists in 1997.

The Intermediary points out that in 1996, the amounts paid to the contractor for skilled PT was $122,319. The charges recognized in the finalized cost report were $204,129. The direct cost mark-up was approximately 67% (when other stepped down costs are added to direct costs the margin shrinks). For purposes of this analysis, the relationship between direct costs and charges makes the point. The witness testified that the skilled PT unit cost and charges were $18 and $31.69, or a mark-up of 76%. This discrepancy is not material. For routine restorative services, the equivalent labor cost was $40,735. In response to the Intermediary's inquiry as to the associated units and revenue, the Provider identified 8,517 units and $2,839 in charges. Applying those figures identified a unit cost of $ 4.78 and a unit charge of 0.33 cents.

The Intermediary contends that the math demonstrates that the charging structure was inappropriate to use for cost apportionment. The facts present a direct cost mark-up of 76% for a skilled PT service and a 600% discount for routine restorative services. If that is the charge structure, it cannot support including routine restorative costs and charges in the PT cost center. The HCFA Pub. 15-1 §2220 requirement of an equitable charge structure has been violated.

The Intermediary argues that the Provider's suggestion that the units might be accurate but charges were not imposed on all patients means that condition 5 of HCFA Pub. 15-1 § 2220 was not met.

The Intermediary contends that in reviewing the FYE 1997 cost report, it is clear that the same circumstances as in FYE 1996 are present. For the 1997 cost report the Intermediary found :

1. The direct cost of skilled PT services was $121,150. Total PT charges on the as filed and final cost report was $189,627. This reflects a mark-up of 57%;

2. Routine restorative direct costs were $37,663. If the facility had an equitable relationship between costs and charges, as per the regulation at 42 C.F.R. §413.53, the associated charges would be approximately $58,000. It is obvious that the PT charge statistics do not include anything close to the proper level of routine restorative charges.

3. This establishes that whatever was wrong with the Providers' charge practices in 1996, existed in equal force in 1997.

The Intermediary argues that the Providers' contention that it couldn't bill the State for routine restorative services for Medicaid patients reflects a lack of understanding of the concept of using charges to apportion costs and charges as a measure of the consumption of resources (costs). The provision of a routine restorative service consumes resources. If a statistic to reflect that use of resources is not in the total charges, then other payors will be absorbing the costs of those services. If Medicare is that other payor, excluding a charge clearly violates HCFA Pub. 15-1

§2220, and shifts costs. It is irrelevant what or how the State Medicaid Program may or may not pay.

ISSUE 2

As to the classification of salaries for allocating, employee Health and Welfare, it presents the identical concept to the question of what cost center should the salaries, of a class of workers be assigned to. Therefore issue 2 has the identical arguments from the parties as issue 1.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws 42 U.S.C.:

2. Regulations:

§§ 405.1835-.1841	-	Board Jurisdiction
§413.53et seq.	-	Determination of cost of services to beneficiaries

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

§2203	-	Provider charge structure as basis for apportionment
§2220	-	Part A services furnished by the physical Therapy Department of a hospital or skilled nursing facility to its inpatients.

4. Other:

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

California Special Care Center (La Mesa, Calif.) v. Blue Cross and Blue shield of California, PRRB Dec. No. 98-D18, Medicare and Medicaid Guide ("CCH") §46,007, Jan 14, 1998, dec. rev. HCFA Adm., March 4, 1998.

Brae Loch Manor Health Care Facility v. Blue Cross and Blue Shield Association,PRRB Dec. No. 2000-D83, Medicare and Medicaid Guide ("CCH") §80,568, Sept. 19, 2000. Rev. HCFA Adm. Dec. Medicare and Medicaid Guide ("CCH") §80,622, Nov.20, 2000.

FINDINGS OF FACT,CONCLUSIONS OF LAW AND DISCUSSION:

ISSUE 1

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony presented at the hearing, and post hearing briefs finds and concludes that the provider did not meet the requirements of paragraph 5 of HCFA Pub. 15-1 §2220 and therefore cannot claim the cost of the restorative aides as an ancillary cost.

The Board finds that there are five requirements which must be met for a provider to claim the restorative aide cost as an ancillary service. The requirements are found in HCFA Pub. 15-1 §2220 and state:

1. The services are medically necessary;

2. The treatment furnished is prescribed by a physician;

3. All services provided by salaried employees (whether full-time or part-time) of the physical therapy department of the provider (if, on the other hand, the services are furnished under arrangements, the services would not be covered since under the law, routine restorative nursing services must be furnished by the provider directly, and cannot be covered if furnished under arrangements);

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 services in question);and

5. Charges are equally imposed on all patients.

The Board finds that the Provider did not meet the last requirement of HCFA Pub. 15-1 §2220 which states: "Charges are equally imposed on all patients." Although alluded to in the testimony at the hearing, there was no evidence in the record to substantiate a charge structure. In the testimony:

Q. ..are you familiar with the rate relationship and the daily rate as between private pay patients and Medicare patients?

A. The usual and the charge structure is the same for both payers or Medicaid as far as that is concerned, yes[1]

The Board also finds that the questioning by Mr. Barker indicates that there was no charge structure. By Mr Barker:

[1]Tr at 64

Q. did you say that this information was not included and not used in preparing the ‘96 report, these units and charges?

A. That is correct.

Q. What was used in the 1997 report?

Q. For restorative, routine restorative.

A. the charges?

Q. Yeah.

A. they did not use it. They did not bill Medicaid or Medicare. There were no charges for them.

Q. So you used the regular PT?

A. That is correct.

Q. so you did not...how about units or anything else like that?

A. No.

This testimony indicates that there was no charge structure.

The Board finds that the Providers were not in compliance with HCFA Pub. 15-1 §2203 which states in part:

> [w]hile the Medicare program cannot dictate to a provider what its charges or charge structure should be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program.

Id.
The Board concludes that the Providers did not have an adequate charge structure as required by Section 5 of HCFA Pub. 15-1 §2220, (charges equally imposed on all patients). The Board also concludes that the Providers were not in compliance with HCFA Pub. 15-1 §2203 which states:

> So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing services.

Id.

Since the Providers did not have a proper charge structure, the Boards finds that the costs of the restorative aides cannot be allocated to a separate ancillary department and must be included in routine cost.

ISSUE 2

The Board finds that since the Providers did not have an adequate charge structure with which to allocate PT costs, the Intermediary's reclassificatiom of the salary used for the employee health and welfare worksheet B-1 overhead allocation basis was proper.

DECISION AND ORDER:

The Providers did not have an adequate charge structure to enable the cost of the restorative aides to be allocated to an ancillary cost center. The Intermediary's adjustments are 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: May 15, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman