PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D45

PROVIDER –
ProCare Home Health
Oxnard, CA

Provider No. 36-6007

vs.

INTERMEDIARY –
Blue Cross/Blue Shield Association/
Wellmark, Inc.

DATE OF HEARING-
March 13, 2001

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-0095

INDEX

ISSUE:

Was the Intermediary=s adjustment reclassifying the community liaison=s compensation to a non-reimbursable cost center proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Procare Home Health (Provider) is a freestanding home health agency located in Oxnard, California. In its as-filed cost report, the Provider submitted $31,727 in total compensation expense for the Community Liaison Employee (CLE) in the allowable Administrative and General (A&G) cost center. The CLE visited doctors= offices and other health care institutions to provide information about home health agency services and to obtain necessary documentation. He maintained a log showing the date of the visits, and the purpose of the visits. Wellmark (Intermediary) determined that this cost was a non-reimbursable marketing expense and reclassified it to a non-reimbursable cost center. As a result of this action, additional overhead costs were adjusted to the non-reimbursable cost center in the amount of $42,125. The Provider disagreed with the Intermediary=s adjustment and appealed to the Provider Reimbursement Review Board (Board), in accordance with the regulations at 42 C.F.R. ''1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount in contention is approximately $73,852.

The Provider was represented by John W. Jansak, Esq. of Harriman, Jansak & Wylie. The Intermediary was represented by Bernard M. Talbert, Esq. of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that its CLE visited doctor=s offices and other health care institutions to provide them with information about the Provider. The CLE also informed them of the necessary documentation needed regarding beneficiaries being served by the Provider. These services are specifically allowable under HCFA Pub. 15-1 '2113 et seq. The Provider produced records to support the activities of this employee.

The Provider points out that HCFA Pub. 15-1 ' 2113 et seq. states:

> A[h]ome health coordination, also known as intake coordination, is intended to manage and facilitate the transfer of patients from a hospital or skilled nursing facility (SNF) to the care of a home health agency (HHA)@.

The Provider also points out that some of the CLE activities were making contacts with other professional organizations. The Provider notes that this is also an allowable activity, as per HCFA Pub. 15-1 '2136 et seq. which states:

> A[C]osts of activities involving professional contacts with physicians, hospitals, public health agencies, nurses associations, State and county medical societies, and similar groups and institutions to appraise them of the availability of the provider=s covered services are allowable.@

Id.

The Provider argues that its CLE was visiting physicians= offices to talk with the physicians and/or staff. This is critical because in the Intermediary=s workpaper the auditor stated: A[t]he time studies indicate most of (employees) time was spent with physicians going over referrals. Thus, the main function of the Community Liaison are physicians relations and community relations.@[1] The Provider contends that the language is almost the same language found to be allowable in HCFA Pub. 15-1 '2136 et seq.

The Provider argues that the Intermediary improperly disallowed the cost of the CLE and placed such costs in a non-reimbursable cost center. Approximately 4.3% of the A&G was allocated to the non-reimbursable cost center which increased the total disallowed costs to $73,852. The Provider contends that a portion of overhead related to claims was shifted to this cost center. Also, nursing supervision was shifted to this cost center. Neither of these activities has anything to do with the activities of the CLE. By shifting these costs to the non-reimbursable cost center, the Intermediary improperly shifted costs away from the Medicare program. Cost shifting is an improper action as described in the Medicare regulation at 42 C.F.R. '413.9 et seq. which states in part:

> AThe objective is that under the methods of determining costs, the cost with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.@

The Provider points out that in Butler Hospital (Providence RI) v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of Rhode Island, PRRB Dec. No. 88-D8, December 16, 1987, Medicare and Medicaid Guide (CCH) &36,698, Aff=d HCF Adm. Decision Feb. 16, 1988, Medicare

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[1] See Providers Post Hearing Brief.

and Medicaid Guide (CCH) ¶ 37,002, the Board disallowed the provider=s cost finding methodology in determining costs related to a rental area. Although the provider=s methodology was rejected, A[t]he Board noted that certain of the provider's A&G costs were not associated with the non-allowable rental area. Accordingly, the Board allowed the Provider to carve out these costs and allocate them separately from the other A&G costs.@ The Administrator agreed pointing out, A[t]he object is that there be no cross-subsidization of Medicare and non-program patients.@ As noted by the Administrator, '2313.1 of HCFA Pub. 15-1 allows for fragmentation and selective allocation of various A&G costs.

The Provider also points out that in the Board decision in Rhode Island Hospital (Providence RI) v. Blue Cross and Blue Shield Association /Blue Cross and Blue Shield of Rhode Island, PRRB Dec. No. 85-D69, July 1, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,870, Aff=d HCF Adm. Decision August 26, 1985, Medicare and Medicaid Guide (CCH) ¶ 34,968, there was no approval for discrete costing, but the Board approved the method used by the hospital because it was more accurate than the step-down. The Administrator agreed that use of the conventional step-down in that case was unreasonable and inaccurate.

The Provider also points out that in Miami Valley Hospital (Dayton, OH) v. Blue Cross and Blue Shield Association / Community Mutual Insurance Company, PRRB Dec. No. 93-D99, September 24, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,746, it was determined that installation costs related to telephone equipment for administrative telephone costs should not be allocated to patient telephones because under 42 C.F.R. '413.9(b) et seq: A[t]he costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.@ Id.

The Provider notes that at the hearing, the Provider administrator testified that as he read the daily logs, nearly all of the visits were covered visits. As an example, Aon 9-13 in the office, there was an appointment with . . . and went over cholesterol screening and some Protime machines that would help us in getting cardiology referrals.@[2] These same kinds of activities were stated in other parts of the testimony. On cross examination, the Intermediary=s auditor testified that Agoing to a physician and educating them on the services that are available@[3] was an allowable activity. The auditor agreed that open house invitations that were delivered would be allowable in certain circumstances. However, he found some log entries vague.

INTERMEDIARY= S CONTENTIONS:

The Intermediary argues that the adjustment to disallow CLE cost was made in accordance with HCFA

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[2] Tr. at 36.

[3] Tr. at 170.

Pub.15-l '2113 et seq, Home Health Coordination, '2113 - Patient Solicitation Activities, '2102 et seq -Costs not related to patient care, '2136 et seq-Unallowable advertising costs, and '2328-Distribution of general services costs to nonallowable cost areas.

The Intermediary contends that the activities performed by the CLE were for patient solicitation activities. These activities included visiting physicians, hospitals and senior centers to request referrals and providing gifts and entertainment, such as movie tickets and donations, to influence these parties to refer patients to the Provider. The Intermediary contends that the Provider spent $1,765 in reimbursement to the community liaison for nonallowable gifts and luncheons for physicians.

The Intermediary points out that the CLE maintained a worksheet describing his activities for the period from July 14 to November 22, 1995. The Provider was unable to provide documentation to support the Community liaison activities during the remainder of the year. Based on some of the descriptions found in the worksheet, the Intermediary contends that those visits were aimed at obtaining more referrals. The descriptions do not support the Provider=s contentions that these contacts were made only for the purpose of distributing information about the Provider's services or completing forms necessary for the Provider's patients.

The Intermediary contends that time spent arranging health screenings and physician speaking engagements for the general public is nonallowable. According to HCFA Pub. 15-1 '2102 et seq-Costs not related to patient care:

> ACosts not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reasonable costs.@

Id.

The Intermediary also points out that HCFA Pub. 15-1 ' 2136 et seqC Unallowable advertising costs states in part: ACosts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable.@

The Intermediary argues that the worksheets prove that the CLE engaged in nonallowable solicitation activities and that they were the primary duties of the CLE. The worksheets do not contain the actual time spent by the CLE. The Intermediary points out that activities such as blood pressure screenings for the general public, county fair booths and lectures by physicians for the general public are not related to the care of the Provider=s patients and are aimed at identifying and soliciting new patients to utilize the Provider=s services. These types of activities are specifically disallowed in the HCFA Pub. 15-1 '2113 which states in part: AHHAs must be able to produce supporting records such as the time logs to substantiate their statements pertaining to the time spent by HHA personnel in the various activities.@

The Intermediary argues that the CLE=s primary function was to obtain referrals and to get business away from competitors. Some of the entries in the work sheet show that the CLE was engaged in marketing or patient solicitation efforts.

The Intermediary argues that it properly reclassified the non-allowable cost of the CLE to a non-reimbursable cost center so that overhead cost related to the nonallowable activities were properly assigned using step-down cost finding. HCFA Pub. 15-1 '2328 et seq states:

> Nonallowable cost centers to which general service costs apply should be entered on the cost allocation worksheets after all General Service Cost Centers. General service costs would then be distributed to the nonallowable cost centers in the routine Astep-down@ process.

Id.

The Intermediary contends that using a discrete cost finding methodology as proposed by the Provider for allocation of only specific overhead would be inaccurate and unnecessary. The Provider did not maintain time records during the 12-31-95 fiscal year which would have enabled the Intermediary to perform accurate direct cost finding. Therefore, the step-down method is appropriate considering that the CLE did use a portion of the Provider=s overhead costs, including office space, equipment, utilities and supplies.

CITATION OF LAW. REGULATIONS AND PROGRAM INSTRUCTIONS:

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.9 et seq.	-	Cost Related to Patient Care

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

' 2102 et seq.	-	Costs not related to patient care
' 2113 et seq.	-	Home Health Coordination (Or Home Care Intake Coordination) Costs General
' 2136 et seq.	-	Allowable Advertising Costs
' 2313.1	-	Use of Provider=s Unique Cost Centers

' 2328 et seq. - Distribution of general service costs to non-allowable cost areas

3. Case Law:

Butler Hospital (Providence RI) v. Blue Cross and Blue Shield Assn./ Blue cross and Blue Shield of Rhode Island, PRRB Dec. No. 88-D8. December 16, 1987, Medicare and Medicaid Guide (CCH) & 36,698, Aff'd HCFA Adm. Dec. Feb. 16,1988, Medicare and Medicaid Guide (CCH) & 37,002

Rhode Island Hospital (Providence.RI) v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of Rhode Island, PRRB Dec. No. 85-D69, July 1, 1985, Medicare and Medicaid Guide (CCH) & 34,870, Aff-d HCFA Adm. Dec. August 26, 1985, Medicare and Medicaid Guide (CCH) & 34,968.

Miami Valley Hospital (Dayton, OH). v. Blue Cross and Blue Shield Association./Community Mutual Insurance Company. PRRB Dec. No. 93-D99, September 24, 1993, Medicare and Medicaid Guide (CCH) & 41,746

FINDINGS OF FACT. CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, testimony at the hearing and evidence presented, finds and concludes that the Intermediary properly disallowed the Provider=s cost of the Community Liaison Employee and properly established a non-allowable cost center.

The Board finds that the Provider claimed Community Liaison costs on its December 31, 1995 cost report. The Intermediary disallowed this cost due to inadequate Provider time records and the Intermediary=s belief that at least part of the Community liaison=s time was spent performing non-reimbursable activities geared toward patient solicitation. The Provider=s evidence which consisted of logs, and not time logs, indicated notations which were vague and seemed to indicate the Community Liaison was engaging in marketing activities as well as allowable Community Liaison activities. The Board notes that if the Provider had proper documentation (Time Sheets) a portion of the Community Liaisons cost would have been reimbursable. However, without the time sheets the Board is unable to determine the amount of time spent on reimbursable activities.

The Board is unable to determine the amount of time the Community Liaison employee spent in marketing and allowable Community relation activities, since there was no time records for the employee. The Board gave the Provider the opportunity to provide additional documentation. The Board requested that the Provider submit a job description of the Community Liaison employee and time records. However, this information was not received by the Board. Since there were no time

records, the Board can not accept the Provider=s contention that between 90 and 93% of the Community Liaison's time was utilized for allowable community relation activities.

The Board finds that since the Community Liaison employee was engaged in non-reimbursable activities, and because there was a lack of documentation to establish discrete cost finding, it was proper for the Intermediary to establish a non-reimbursable cost center. By establishing a non-reimbursable cost center the Intermediary was able to properly allocate some of the Provider=s overhead via the step-down method to the appropriate non-reimbursable cost center.

DECISION AND ORDER:

The Intermediary=s adjustments disallowing the Provider=s claimed Community Liaison employee costs were proper. The Intermediary's adjustment establishing a non-reimbursable cost center was proper. The Intermediary=s adjustments are upheld.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Stanley J. Sokolove

Date of Decision: September 13, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman