PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D5

PROVIDER -
Grace Nursing Home
Clinton, LA

Provider No. 19-5258

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Trispan Health Services

DATE OF HEARING-
June 21, 2001

Cost Reporting Period Ended -
March 31, 1993

CASE NO. 96-0550

INDEX

ISSUE:

Was the Intermediary's denial of a routine cost limit exemption as a new provider proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Grace Nursing Home (Provider) is a proprietary corporation organized and existing under the laws of the State of Mississippi, having its principal place of business in Clinton, Louisiana. On July 26, 1990, the Provider was certified as a skilled nursing facility as defined in 42 U.S.C. § 1395(x)(j), and was classified as a provider within the meaning of 42 U.S.C. § 1395(x)(u). Prior to this time the Provider operated as an Intermediate Care Facility in accordance with 42 U.S.C. § 1396r(a).

On October 20, 1991, the Provider requested an exemption to the routine service cost limits for its FYE 3-31-93 cost report, in accordance with 42 C.F.R.§ 413.30 et seq. On September 27, 1994, the Provider received its FYE 3-31-93 Notice of Program Reimbursement (NPR). On April 4, 1995, Trispan (Intermediary) sent a letter to the Provider requesting an affidavit as to the validity of the Provider's initial letter requesting an exemption to the RCL dated October 20, 1991. On August 2, 1995, the Intermediary forwarded HCFA's denial of the Provider's October 21, 1991 request for exemption. On January 19, 1996, the Provider filed its request for a hearing with the Provider Reimbursement Review Board (Board) in accordance with the regulations at 42 C.F.R.§§ 405.1841-1845. The Board reviewed the Provider's request and accepted jurisdiction. The amount in controversy is approximately $132,499.

While the Provider was waiting to receive a final determination on its request for exemption for its FYE 3-31-93 cost report, the Provider timely filed its request for exception for the 3-31-94 cost report. The Intermediary granted the Provider an exception for the FYE 3-31-94.

The Intermediary reopened the Provider's FYE 3-31-93 cost report to make additional adjustments to the Routine Cost Limits (RCLs). On December 13, 1996, the Provider received a revised NPR based on the Intermediary's additional adjustments to the Provider's RCLs. On January 28, 1997 the Provider requested additional information supporting the Intermediary's decision to decrease its RCLs. On March 19, 1997 the Provider submitted a request for an exception to the RCLs. To date the Provider has not received a decision by HCFA or the Intermediary regarding its request for exception.

The Provider was represented by Julie A Bowman, Esq. and Tom Kirkland, Esquire, of Copeland, Cook, Taylor &Bush. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it qualified as a "New Provider" for its FYE ended 3-31-93. The Provider requested an exemption as a "new provider." The intent of the "new provider" exemption is to allow a provider to recoup the higher costs normally resulting from low occupancy rates and start-up costs during the time it takes to build its patient population.

The Provider points out that a "new provider" is defined in the regulations to mean "a provider that has operated as the type of facility for which it has been approved for participation in the Medicare program (for example, as an SNF or an HHA) under present and previous ownership for less than three full years." 42 C.F.R. §413.13.

The Provider contends that the term "equivalent" as it relates to an SNF has been interpreted by the Secretary to refer to whether or not, prior to certification, the institutional complex as a whole engaged in providing either (1) skilled nursing care and related services for residents who require medical or nursing care; or (2) rehabilitation services for the injured, disabled or sick persons. In determining whether a service is skilled or not we look to those services identified in 42 C.F.R. § 409.33 et seq.

The Provider points out that the regulation at 42 C.F.R. § 409.31 provides certain requirements which define the level of care required for skilled services. "As used in this section, skilled nursing and skilled rehabilitation services means services that: (1) Are ordered by a physician; (2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and (3) Are furnished directly by, or under the supervision of, such personnel." Moreover, the: "Specific conditions for meeting level of care requirements" are as follows: "(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis." 42 C.F.R. § 409.31. In essence, the Provider contends that to be considered a skilled service the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

The Provider contends that it was not operating as an SNF or its equivalent prior to 1990. The Provider disagrees with the Intermediary's assertion that if it rendered one instance of service to one patient where the service would be construed as a skilled service, then the Provider is not entitled to an exemption to its routine cost limits regardless of its actual capabilities or the extent to which the services were provided, if at all. The Intermediary utilized: (1) the OSCAR Data Report, a form created and utilized for the purpose of granting or denying provider exemption requests; (2) a Provider Service Survey; and (3) a document entitled Information Needed for the Review of SNF Exemption Request to Cost Limits. Using these documents and absent any onsite review of actual services rendered by the facility during the applicable time frame, the Intermediary determined that it is plausible that the Provider was providing instances of service to one or more patients which could be considered skilled; and therefore denied the Provider's request for exemption. The Provider contends that when viewed together, it is apparent that these documents do not conclusively show that the Provider was operating as a skilled nursing facility or its equivalent prior to July 26, 1990. Moreover, the documents themselves are vague, arbitrary and misleading, and therefore inappropriate for use in determining whether a facility is operating as an SNF or its equivalent.

The Provider contends that it is questionable whether the documents used by the Intermediary, or services identified in those documents, were used in a manner which justifies denial of the Provider's exemption request. The Provider contends that it was not an SNF due to the staff's lack

of basic training and education to operate an SNF. The director of nursing referred to patients' injuries as "boo-boos" rather than, for instance, stage 1-4 decubitus pressure ulcers.[1] The Provider lacked policies and procedures and formalized training for rendering skilled nursing services as well as lacking the actual staff needed to operate as an SNF. The Provider lacked the knowledge of the Medicare program, documentation requirements and, in general, the Provider lacked the capabilities to admit, treat and care for skilled patients as of July, 1990.

The Provider points out that an area identified by the Intermediary as a skilled service (skin pressure ulcers), purportedly precluded the Provider's request for exemption to its RCL. On the OSCAR report there is no indication as to the skilled care being given for that particular area or that the pressure ulcers were of the severity to qualify them for skilled services. The OSCAR report shows that patients at the facility had three or four pressure ulcers. This in itself does not indicate that skilled care was being provided for these particular areas, that they were of the severity to require skilled services or that they were part of a "comprehensive care plan."[2]

The Provider points out that 42 C.F.R. § 409.33 et seq, provide that the "treatment of extensive decubitus ulcers or other widespread skin disorder" qualify as skilled nursing services. However, under 42 C.F.R. § 409.33 et seq, treatment of minor skin problems is not skilled care, but rather, personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in 42 C.F.R. § 409.33 et seq, a distinction which the Intermediary fails to make or recognize. The Intermediary has stated that they are not concerned with the level of care, but rather, would classify all pressure ulcers as requiring skilled nursing services regardless of the actual level of care required or service rendered.[3]

The Provider contends that the "skilled services" identified by the Intermediary were not necessarily "skilled" nor rendered in a manner which qualified the Provider as an SNF or its equivalent. Moreover, the State of Louisiana, in recognizing the limited number of SNF facilities available in Louisiana during the late 1980s, allowed Intermediate Care Facilities to provide instances of certain services as personal care or custodial care type services. Under this limited program, a facility could render an instance of service to one patient on a month to month basis. This allowed patients in an Intermediate Care Facility to receive certain services without having to

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[1] Tr at 98

[2] Tr at 112

[3] Tr at 310-316

seek other alternatives such as placement in long-term care facilities or hospitals. The Provider had two or three patients on this program.

The Provider argues that none of the evidence utilized by the Intermediary addressed whether an instance of service was provided under this program or the extent to which these services were provided. However, the Provider argues that it has submitted ample evidence and testimony to illustrate that it was not operating as an SNF or its equivalent prior to Medicare certification. It was not providing skilled services on a regular basis or the type of services that would equate it to an SNF.

The Provider argues that the documents utilized by the Intermediary in determining whether the Provider was operating as an SNF or its equivalent are vague, arbitrary and misleading, and therefore inappropriate for use in determining whether the Provider qualified for an exemption. The Intermediary relies on the OSCAR Reports; the Provider Service Survey; and a document entitled "Information Needed for the Review of SNF Exemption Request to Cost Limits" in determining whether the Provider was operating as an SNF or its equivalent.[4] Using these documents and absent any onsite review of actual services rendered by the facility during the applicable time frame, the Intermediary determined that the Provider was providing service which could be considered skilled to one or more patients, and therefore denied the facility's request for exemption.

The Provider maintains that neither the Provider Service Survey nor OSCAR database identifies the actual level of service provided, the totality of circumstances under which that service was rendered or whether the Provider was the actual provider of that service. Based on the Intermediary witness's own testimony, she could not rely on the OSCAR Report to conclusively validate whether a skilled service was even provided.[5]

The testimony of the Intermediary's witness illustrates the inconclusive results produced by the OSCAR data.

Q. You can't rely on the OSCAR data to support there was a patient there in any of those four years that had a feeding tube, can you?

A. That has a feeding tube?

Q. Correct.

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[4] Tr at 284-286

[5] Tr at 304-307

A. No.

Q. Is it your position that the OSCAR data supports the fact that there were patients in Grace Nursing Home between 1986 and 1989 that had feeding tubes?

A. The OSCAR data does not indicate any patients.

Q. Right.

A. But the provider's information does.

Q. Now in terms of respiratory care we show three patients in the facility on November 2 of 1989.

A. Uh huh.

Q. Do we know what type of respiratory care those patients were receiving?

A. We know from the definition that it could have been oxygen, it could have been IPPB, it could have been a whole different host of things.

Q. Now, with regard to pressure sore information on the OSCAR data,...

A. Uh huh.

Q. can you tell by looking at that whether or not the pressure sore care that is being given is for level 1, 2, 3 or 4 pressure sores?

A. You mean the staging?

Q. Yes.

A. No. And we're not interested in what stage it is.

Q. Look at paragraph.. subparagraph 5[42 C.F.R. § 409.33(f), Personal Care Services] above that and read that for us.

A. "Prophylactic and palliative skin care including bathing and application of creams or treatment of minor skin problems."

Q. Okay. That's not skilled care, is it?
A. It can be in certain instances if it's required to be done by skilled nursing personnel.

Q. Okay, Looking back at the OSCAR data on the pressure sores...

A. Uh, huh

Q... there is no way you can look at that and tell me that is. .that all those patients required. were level 3 and level 4...

A. I'm not interested in whether they're level 3 or level 4.[6]

The Provider maintains that the Provider Service Survey and the OSCAR Database, when viewed in their totality, lead to inaccurate assessments of data provided by facilities; and "as a result, the Intermediary's reliance on these documents for determine whether Grace qualified for an exemption to its routine cost limits was inaccurate, inconclusive and, therefore, inappropriate."[7]

The Provider contends that because of the Intermediary's untimely response to the Provider's request for exemption and numerous irregularities in its initial NPR, the Provider was not afforded the opportunity to seek other alternative relief; i.e., Request for Exception based upon its initial NPR. Had the Intermediary CMS (formally HCFA) responded in a timely fashion as required under 42 C.F.R. § 413.30et seq and HCFA Pub. 15-1 governing instructions, the Provider would have been able to request an exception to its FYE 3-31-93 cost report, and as is evidenced from subsequent years, would have been granted that exception.[8]

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[6]Tr at 310-317

[7]Provider's Post Hearing Brief P 26-27

[8]Provider Exhibit 12

The Provider points out that in Canonsburg General Hospital Skilled Nursing facility v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D 10, December 13, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,385. the Board alluded to the fact that where a provider is prejudiced by the HCFA and Intermediary's actions, it may be entitled to relief where the Intermediary and HCFA' s tardiness has an effect on a provider's ability to timely file exception requests.[9] See also; Beverly Hospital v. Bowen, 872 F.2d 483, 487 (D.C. Cir. 1989). Holding that "where HCFA's conduct prevents timely action by a provider, the task for the agency is conscientiously to remold the situation to approximate what it should have been initially, and thereby avoid physicians hardly worthy of our great government. Thus, where government agencies improper actions prejudiced a provider's rights, all applicable limitation periods should be tolled or the provider afforded the relief requested."[10] Accordingly, the Provider is entitled to its exemption request, or, in the alternative, the Provider should be allowed to submit an exception for its FYE 3-31-93 cost reporting period based upon its initial NPR.

INTERMEDIARY' S CONTENTIONS:

The Intermediary contends the Provider performed skilled nursing services prior to its Medicare certification. CMS used the On-Line Survey and Certification and Reporting System ("OSCAR"), a CMS database used for survey and certification activities, to determine if, in fact, the supporting documentation provided by the Provider with its request for Medicare certification was accurate. CMS found that the Provider had provided skilled nursing and related services as early as November 7, 1986. The data found in OSCAR was collected from the Residents Census and Characteristics Reports (Form HCFA 519) submitted by the Provider to the survey team at the time of the Provider's annual surveys. The data revealed that the Provider had provided certain skilled nursing and related services prior to November of 1988. These services included, but were not limited to: insertion of sterile irrigation and catheters, care of pressure ulcers, and application of dressings involving prescription medications and aseptic techniques.[11] The Intermediary also points out that the Provider reported to CMS on its Form HCFA 671 that it had a physical therapist, speech pathologist and occupational therapist onsite to provide rehabilitative services to its residents. It also reported having a 50-bed ventilator unit.

The Intermediary contends that the Provider did not solely provide custodial care to its residents, but in fact did provide both skilled nursing and related services and rehabilitative services as indicated in the previous paragraph. CMS determined that the Provider had operated in the manner of an SNF, or its equivalent, by providing skilled nursing and related services and rehabilitative services for more than three years prior to its certification in the Medicare program.

The Intermediary contends that an institution having provided skilled nursing or rehabilitative services for three or more years prior to certification under past or present ownership, regardless

[9]Provider Exhibit 36

[10]Provider Exhibit 36

[11]Intermediary Exhibit 9

of the specific volume, is not entitled to the new provider exemption. Although a nursing home might not have furnished skilled nursing or rehabilitative services as frequently as a skilled nursing facility providing those services on a continuous basis, the regulation at 42 C.F.R. 413.30 et seq. makes no allowance for institutions providing a low volume of skilled nursing services prior to certification in the Medicare program.

The Intermediary points out that CMS informed the Provider in the determination of its exemption request that it should seek relief from the effect of the imposition of the skilled nursing facility routine service cost limits through the exception process. Relief from the cost limits for the provision of atypical services is provided for under the exception provision found at 42 C.F.R.§ 413.30 et seq. As stated at 42 C.F.R. § 413.30 et seq: "limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the Intermediary." Id. An exception may be granted if an institution can demonstrate that it has a lower than average length of stay, higher than average ancillary cost per day and higher than average Medicare utilization than that of its peers. The Intermediary has no record that the Provider ever requested an exception for the March 31, 1993 cost-reporting year. The Provider requested and received an exception for the March 31, 1994 cost-reporting year in the amount of $17.03 per day, for a total of $92,149 in additional reimbursement above the cost limit for that year.[12]

The Intermediary points out that for purposes of the RCL exemption, a new provider is defined at 413.30 et seq as follows:

> (e) Exemptions. Exemptions from the limits imposed under this section may be granted in the following circumstances; (2) New provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the providers first cost reporting period beginning at least two years after the provider accepts its first patient.

The Intermediary contends that CMS viewed the Provider prior to its request for Medicare certification as a nursing facility. A nursing facility provides skilled nursing and related services or rehabilitation services.[13] The fact that the Provider was providing skilled nursing services as far back as 1986 was established. The date of the Medicare certification was July 26, 1990. As evidenced by the OSCAR in Intermediary exhibit 9 for 1986, the facility was providing indwelling catheters, external catheters and treatment for pressure ulcers. Later year OSCAR's show similar

[12]Intermediary Exhibit 45

[13]Tr at 253

services.[14]

The Intermediary points out that in the new provider exemption cases which have proceeded through the PRRB and beyond, the appeal most supportive of the Intermediary's position is Mercy St. Teresa Center (Mariemont, Ohio) v. Blue Cross and Blue Shield Association/ AdminaStar Federal PRRB Dec. No 98-D64 June 16, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,006 which applied the same regulations under very similar facts.

The Board found that although the Provider did not furnish skilled and rehabilitation care as frequently as a skilled nursing facility, it did furnish a low volume of some skilled and rehabilitation services. The regulation at 42 C.F.R. § 413.30 et seq makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF. That regulation states in part:

> "The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient."

Id.

Since the Provider did furnish some skilled and rehabilitation services for three years prior to certification, regardless of the specific volume, it is not entitled to the new provider exemption.

[14]Tr at 267-269

The Board's interpretation in Mercy St. Teresa was affirmed by the United States District Court for the Southern District of Ohio.[15] There was no further action on this case. The Intermediary contends that as an administrative precedent, Mercy St. Teresa strongly supports the Intermediary's contentions.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395(x)(j)	-	Skilled nursing facility
§ 1395(x)(u)	-	Provider of service
§ 1396r(a)	-	Nursing facility defined

2. Regulations:

§ 405.1841-.1845	-	Board Jurisdiction
§ 409.31	-	Level of care requirement
§ 409.33 et seq.	-	Examples of skilled nursing and rehabilitation services
§ 413.13	-	Amount of payment if customary charges for services furnished are less than reasonable costs
§ 413.30 et seq.	-	Limitations on reasonable costs

3. Provider Reimbursement Manual, Part 1, (HCFA Pub. 15-1):

4. Cases:

Canonsburg General Hospital Skilled Nursing Facility v. Blue Cross and Blue Shield Assoc., PRRB Dec. No 2000-D10, December 13, 1999, Medicare and Medicaid Guide ("CCH") ¶80,385.

Beverly Hospital v.Bowen, 872 F.2d 483 (D.C. Cir. 1989).

[15]Intermediary Exhibit 47

Mercy St. Teresa Center, (Mariemont, Ohio) v. Blue Cross and Blue Shield Assn./ Administar Federal, PRRB Dec. No 98-D64, June 16, 1998 Medicare and Medicaid Guide ("CCH") ¶80,006.

Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998 ("CCH") Medicare and Medicaid Guide ¶ 46,224, upheld by U.S.D.C. Case Number 98-C-553, April 16, 2000, U.S. Court of Appeals (Seventh Circuit) 251 F.3d. 1141 ("Paragon") case.

5. Other:

OSCAR (On Line Survey and Certification Reporting System)
Provider Service Survey
Information Needed for the Review of SNF Exemption Request to Cost Limit.
Residents Census and Characteristics Report (HCFA Form 519)

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 parties' post hearing briefs, finds and concludes that the Provider is not entitled to an exemption to the routine cost limits as a new provider.

The Board finds that the Intermediary offered three types of evidence. One was the On-Line Survey and Certification System (OSCAR report) a CMS database used for survey and certification activities which is a form created by CMS and used to determine if, in fact, the supporting documentation provided by a provider with its request for Medicare certification was accurate. The second document was the Provider Service Survey (PSS). The third document was the Information Needed for the Review of SNF Exemption Request to Cost Limits.

The Board finds that the essential document was the OSCAR. The information for the tabulation of the OSCAR was obtained from the Residents Census and Characteristics Report CMS formally (HCFA Form 519) submitted by the Provider. Upon examination of the OSCAR, the Board found that the Provider had provided certain skilled nursing and related services prior to November of 1988. These services included insertion and sterile irrigation of catheters, care of pressure ulcers, and application of dressings involving medications and aseptic techniques.[16] The Board also notes that physical therapy and occupational therapy were provided by outside contractors.[17]

[16]Intermediary Exhibit 9

[17]Intermediary Position Paper p. 4

The Board finds that the regulation at 42 C.F.R. § 413.30 et seq makes no allowance for institutions providing a low volume of skilled nursing services prior to certification in the Medicare program. The regulation states:

> The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years....

Id.

The record indicates that the Provider did perform certain skilled services for its patients prior to its Medicare certification. Although the volume of the skilled services was low, the regulation is clear. The Provider performed skilled services prior to the three-year period that it was certified and therefore cannot receive an exemption from the routine cost limits. The Board notes that CMS has applied a severe standard in terms of the frequency of skilled nursing occurrences. However, it is bound to follow the standard established by CMS.

The Board notes that CMS has been consistent in its analysis of the OSCAR. The Board takes note of the Milwaukee Subacute and Rehabilitation Center v. United Government Services PRRB Dec. No. 98-D40, April 14, 1998 ("CCH") Medicare and Medicaid Guide & 46,224, upheld by U.S.D.C Case Number 98-C-553, April 16, 2000, U.S. Court of Appeals (Seventh Circuit) 251 F.3d. 1141("Paragon") case. Paragon supports the Secretary's interpretation of the regulatory deference.

The Board notes that a sub-issue in this case was raised by the Provider. This issue relates to the Intermediary's contention that the 1993 exception request was untimely filed. After reviewing the facts the Board finds that the initial Notice of Program Reimbursement (NPR) was issued on September 27, 1994. The Intermediary made corrections to the cost report and issued a revised NPR on December 13, 1996. The Provider requested an exception on March 19, 1997 based on the revised cost report. The Board finds that based on the revised NPR, the Provider timely filed its request for an exception.

The Board finds that because of the Intermediary's untimely response to the Provider's request for exemption and numerous irregularities in its initial NPR, the Provider was not afforded the opportunity to seek alternative relief such as a request for an exception based on its initial NPR. Had CMS responded in a timely fashion as required by 42 C.F.R. § 413.30 et seq, the Provider would have been able to request an exception.

The Board notes that the request for exception to the 1994 Routine Cost Limits was made two years before the revised NPR for 1993 was issued. It was also lost by the Intermediary and finally resolved in November, 1995. The Board notes that the 1994 cost report exception was approved in April, 1996, which was 9 months before the revised NPR for 1993 was issued. The Board concludes that based on the detrimental reliance by the Provider on the Intermediary, the

Intermediary should review the exception request for the cost reporting period ended March 31, 1993.

DECISION AND ORDER:

The Provider is not entitled to an exemption to the routine cost limits as a new provider. The Intermediary's adjustment is affirmed.

The Provider may be entitled to an exception to the routine cost limits. The Intermediary is to review the Provider's documentation and request for exception to determine if it is qualified for the exception.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, DDS

Date of Decision: January 09, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman