PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D22

PROVIDER –
Summit Place, Inc.
Simpsonville, SC

Provider No. 42-5112

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrator

DATE OF HEARING
October 17, 2001

Cost Reporting Period Ended -
September 30, 1997

CASE NO.: 01-0199

INDEX

ISSUES:

1. Was the Intermediary's adjustment combining all SNF and NF cost charges, days, and statistics into one cost center proper?

2. Was the Intermediary's determination that payroll records were not adequate to support nursing service cost allocation to the SNF distinct part proper?

3. Was the Intermediary's determination that the allocation of nursing time resulted in an inequitable allocation of cost to the SNF distinct part proper?

4. Was the Intermediary's decision to disregard statistics and supporting documentation for the allocation of all other general service costs to the SNF distinct part proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Summit Place ("Provider") is a skilled nursing facility ("SNF") located in Simpsonville, South Carolina. The facility is licensed for 132 beds, of which the distinct part SNF was certified for participation in the Title XVIII Medicare program. Palmetto Government Benefits Administrator ("Intermediary") commenced an on-site focused audit of the cost report for the period ended September 30, 1997, in May of 1999. Pursuant to such audit, the Intermediary issued a Notice of Program Reimbursement ("NPR") on September 30, 2000. The Provider did not agree with the findings of the Intermediary and requested a hearing before the Provider Reimbursement Review Board ("Board"). The Board reviewed the Provider's request for a hearing and found that it did have jurisdiction in accordance with the regulations at 42 C.F.R. §§ 405.1835-.1841. The amount of reimbursement in contention is approximately $224,341.

The Intermediary performed the entire audit on site at the Provider's home office and did not visit the Provider's facility. The Intermediary proposed to review two pay periods to determine the adequacy of source documentation to support the direct nursing service time assignment to the distinct part SNF. However, the source documentation, in the form of sign-in sheets that were maintained by the Provider during the period, were not available for review.

The Intermediary agreed to review the Provider's assignment sheets with the payroll records. The Intermediary reviewed only one of the payroll periods. As a result of the review, the Intermediary combined all costs and charges and patient days, based on the absence of adequate source documentation.

After the audit, the Provider submitted to the Intermediary its time cards reports for additional pay periods. These reports show that time allocations were implemented. The Provider in its final position paper submitted information concerning its review of five additional pay periods noting the variances between the time cards and the employee assignment sheets. The Intermediary determined that the variances were significant and maintained that the records of the Provider were not adequate to distinguish the costs between the certified area and the non-certified area of the facility. Therefore, the Intermediary combined the costs of the entire facility to determine the

average cost per patient.

The Provider was represented by R. Bruce McKibben, Jr., Esq., of R. Bruce McKibben, P.A. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the Intermediary violated the zero tolerance policy set forth by Charles R. Booth, former Director of CMS' Cost Policy. Mr. Booth's policy states in part that "minor errors and inconsistencies in the SNF's recordkeeping and cost allocation system" are not to result in determinations of inadequacy.[1]

The Provider is not in agreement with the Intermediary's contention regarding major errors ranging from 80 something percent to 94%, and 60% to 70%. The Provider maintains that for substantiating staffing during the period, any variances within +/- 1%, 3%, or 5% of total hours in the period, are within the realm of minor errors. When using the most stringent criterion, that of variances in excess of +/- 1% of total hours as being major errors, the collective ranges for the Provider were 4.5% to 24.3%, with a composite 15.6% for the group. When using the more reasonable parameters of excesses greater than +/- 3% and/or 5%, the composite for the group was 4.4% and .1%, respectively.

The Provider argues that the samples as designed and administered by the Intermediary were not representative of the fiscal period in dispute. In actuality, the Intermediary reviewed only half of the designated sample and abruptly aborted the reviews. The Intermediary reviewed samples that were not a representative standard for the entire fiscal period being audited, either by design or in actuality. The Intermediary's design sample was composed of two pre-selected periods and then it was further reduced by only reviewing every 5th employee in each pay period. The design of the sample represented less than 2% of the records of the applicable employees when extrapolated over the entire fiscal year.

The Provider contends that the Intermediary should have expanded the sample. Pursuant to the Program Memorandum Intermediary Transmittal I-82 ("PMI"), intermediaries are instructed that if the test results indicate probable errors in the universe, the auditors must document the decision to either expand the sample or project the error to the universe. Neither of these prescribed actions were evident in the audit of the Provider.

The Provider also points out that not only did the Intermediary not expand the sample, in 2 of the 3 instances the Intermediary reduced the samples tested to half of the original design. The PMI instructions indicate that under no circumstances should a sample's error be expanded to the

[1] See Provider's Position Paper.

universe without considering the effect on the universe; it is evident that this instruction was also ignored. The expansion to the universe resulted in an absolute inequitable allocation of costs.

The Provider contends that the requirements for the equitability of the nursing services costs are set forth in § 2340.l.A of CMS Pub. 15-1, which states that:

> [r]egardless of the method used, the result should be an equitable allocation of the nursing service costs between the distinct part and other parts of the facility based on records or notations made at the time the services were rendered.

The Provider contends that it met the above mentioned requirement and that the allocation of nursing service costs was, in fact, equitable prior to the adjustment. The Intermediary's expansion to the universe and resulting adjustments generated inequities of cost allocations to the skilled nursing area and other parts of the facilities.

The Provider argues that contrary the regulation at 42 C.F.R § 413.5, it was denied reimbursement for its reasonable costs associated with the care and treatment of Medicare beneficiaries in a distinct part of a nursing home. The Provider points out that CMS Pub. 15-1 § 2340 does not provide, nor does it permit, nor does it allow, the combining of costs, patient days and statistics for the certified and non-certified areas into one line on the cost report.

The Provider contends that it was improper for the Intermediary to reject the Provider's documents. The Provider's Time Card Reports and Assignment Sheets did accomplish their intended purpose; they reflected the times worked by various individuals at the subject facilities. The records found by the Intermediary to be inadequate as a result of minor discrepancies and or omissions were based on a zero tolerance criterion and are contrary to Medicare regulations. The records were rejected because the entries didn't exactly match and the records were not letter perfect.

The Provider maintains that the Board has long held that letter perfect documentation is not required for supporting costs and cost allocation. Such is exemplified by the Board's decision in the use of daily schedules and average hourly rates to arrive at nursing services costs in Glencrest Rehabilitation Center, Chicago, IL v. Aetna Life and Casualty Co, PRRB Dec. No. 90-D8, Dec. 12, 1989, Medicare and Medicaid Guide (CCH) ¶ 38,286, aff'd CMS Admin., February 2, 1990 Medicare and Medicaid Guide (CCH) ¶ 38,368, and the Board's use of the floor-wide average nursing cost per diem to compute nursing hours for the certified area in Bridgeview Convalescent Center, Bridgeview, IL v. Aetna Life Insurance Co, PRRB Dec. No. 89-D66, Sept. 27, 1989, Mediciare and Medicaid Guide (CCH) ¶ 38,216, aff'd, CMS Adm., November 22, 1989 Medicare and Medicaid Guide ("CCH") ¶ 38,278, both of which were affirmed by the Administrator. Also in Imperial Hospital, Richmond, VA. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 80-D39, June 30, 1980, Medicare and Medicaid Guide (CCH) ¶ 35,355, the Board disregarded the fact that primary source documents were not available due to having been lost, and it relied upon industry norms to support and allow reimbursement for reasonable costs.

The Provider contends that it has substantiated that the care and services provided exceeded the peer group as evidenced by the presence of atypical patients requiring atypical services. It is obvious that the Intermediary's adjustments have resulted in unquestionable inequities of allocation of costs.

The Provider maintains that there were fundamental problems with how the Intermediary conducted the audit and its reliance on only a limited number of documents. The auditors, pursuant to their own rules, asked for records for two pay periods for the year at issue. Then they reviewed 20% or less of the employee records in the selected periods. The Provider argues that representative statistical samples were not used by the auditors. In addition, probable errors in the universe were not addressed by expanding the sizes of the non-representative samples.

The Provider contends that the auditors ignored the single most important rule given its auditors, which was under no circumstances should they make an adjustment for the amount of error in the sample without considering the effect on the universe. The auditors made unlawful adjustments based on expansions to the universe despite inadequate and non-representative samples, without regard to the effect on the universe.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to maintain adequate and verifiable documentation to support its allocation of nursing service costs to the CDP and NF units of the facilities. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, a provider is required to maintain sufficient financial records and adequate cost data to assure the proper determination of costs under the Medicare program. The recordkeeping requirement includes the concept that data be accurate, maintained in sufficient detail to accomplish its intended purpose, and must be capable of verification by a qualified auditor.

The Intermediary argues that the Provider's reliance on Assignment Sheets to support the payroll system to split the nursing time and cost between the CDP and the NF was not adequate. The error rate in time reporting from the assignment sheets was significant. The Provider's system relies on facility personnel to manually correct payroll records to account for time spent in a department different from the employee's home department. There were many instances of errors and failure to accurately make the manual changes. The evidence established that the payroll record, which is the basis of the Provider's time split, is not accurate and does not meet the substantiation requirements of the regulations.

The Intermediary points out that CMS Pub. 15-1 § 2340.1.A presents two methods to allocate nursing service cost between a CDP and a non-CDP. The first method is based on actual time. The second method uses one average cost per hour equally in both units. The Provider attempted to discretely identify time spent by its staff as between the CDP and NF. The Intermediary determined that the methodology for charging time did not adequately identify actual time, was not capable of audit and otherwise did not provide adequate documentation to support the differential in nursing costs claimed in each section of its facility. As a result, the Intermediary reclassified direct nursing costs between the two cost centers based upon calculating an overall average cost per diem.

The Intermediary points out that it requested time reporting records for two time periods. The Intermediary determined that the Provider maintained time record reporting systems which tied into the payroll system and then determined the time split between nursing costs assigned to the CDP and the NF. The system appeared to be acceptable.[2] After the audit, the Intermediary concluded that the Time Card Records could not be relied upon to support the allocation between the CDP and the NF.

The Intermediary contends that there were considerable errors in the Provider's time allocation system. Because the accuracy of the time split requires the staff development coordinator to manually change and correct time split assignments, the error rate in the reporting became significant.

The Intermediary contends that its review of the five additional pay periods further substantiates its inability to rely on the Provider's time recording method. The Intermediary points out that while total variances according to the Provider's calculations may not be significant in certain pay periods, there is a substantial number of employees with significant variances between the time cards and the assignment sheet. The Intermediary determined that for the five periods reviewed, the error rate of employees with a variance was 28%, 29%, 14%, 30% and 26%. Therefore, the Intermediary contends that the significant variance supports its contention that the time card reports do not support the assignment sheets and vice versa.

The Intermediary maintains that the assignment sheets do not appear to be signed by the employee to verify time and assignment areas actually worked. The Intermediary is further unable to determine how shift changes are accounted for on the assignment sheets. Therefore, the Intermediary is unable to place reliance on the assignment sheets. Hence, the Intermediary was unable to verify the accuracy of the Provider's allocation of salary expense between the SNF and NF cost centers.

The Intermediary contends that given the serious flaws in the time reporting process, the use of the average time method was appropriate. Under CMS Pub. 15-1 § 2340(b)(2), the Intermediary

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[2] Tr. at 285.

could not make a finding that the allocations made through the use of the payroll system, with possible adjustments by the staff development director, were accurate allocations of costs. It was at best an estimate without checks or balances. The Intermediary's adjustments which applied the average cost per diem method to determine direct nursing costs in the CDP and NF units of the Provider is supported by the facts and authorities.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement General
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding

2. Program Instructions - Provider Reimbursement Manual (CMS Pub. 15-1):

§ 2340	-	Allocating Nursing Service Costs in Nursing Homes With Distinct Part Skilled Nursing Facility
§ 2340.1.A	-	Actual Time Basis
§ 2340(b)(2)	-	Average Cost Per Diem

3. Cases:

Glencrest Rehabilitation Center, Chicago, IL v. Aetna Life and Casualty Co, PRRB Dec. No. 90-D8, Dec. 12, 1989, Medicare and Medicaid Guide (CCH) ¶ 38,286, aff'd, CMS Adm., February 2, 1990 Medicare and Medicaid Guide (CCH) ¶ 38,368.

Bridgeview Convalescent Center, Bridgeview, IL v. Aetna Life Insurance Co, PRRB Dec. No. 89-D66, Sept. 27, 1989, Medicare and Medicaid Guide (CCH) ¶ 38,216, aff'd CMS Adm., November 22, 1989 Medicare and Medicaid Guide ("CCH") ¶ 38, 278.

Imperial Hospital, Richmond, VA v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 80-D39, June 30, 1980, Medicare and Medicaid Guide (CCH) ¶ 35,355.

4. Other:

Program Memorandum Intermediary Transmittal I-82.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented at the hearing, finds and concludes the Intermediary properly combined all SNF and NF cost, charges, days and statistics into one cost center. The Board finds that the Provider's records were not sufficient to allocate cost between the distinct part and the nursing facility. Provider had to rely on assignment sheets because sign in sheets were not available. Provider admitted that assignment sheets were estimates and would have likely had adjustments based on actual needs of Provider.

The Board finds that the Provider's payroll system relies in part on facility personnel to manually correct payroll records to account for time spent in a department different from the employees' home department. There were many instances of errors and failure to accurately make the manual changes. The evidence established that the substitute records used as the basis for the Provider's time split is not accurate and does not meet the substantiation requirements of the regulation.

The Board finds that the Intermediary did not pursue a zero tolerance policy in conducting the audit. The audit found errors and inconsistencies in the Provider's recordkeeping and cost allocation system which were not considered to be minor errors. Although the Intermediary would not specify what an error rate threshold would be in response to the Board's questions, the Board finds that a significant number of the errors described by the Intermediary were major errors. The Board used CMS Pub. 15-1 § 2340.1, which stresses equitable allocation of costs for guidance. Since the payroll records did not support the allocation of costs, the Intermediary is required to make an average cost adjustment to the cost report.

Despite the in-service training of its employees in the use of the time cards, there was no evidence of any post-training follow up by the Provider's administration, nor did there appear to be any reliable internal control on the part of the Provider's administrators.

With regard to the Provider's complaint that the sample audited was not representative and too small to be extrapolated to the universe of employee records, we find that the issue became moot when the Provider submitted error rate calculations for additional time periods of its own choosing and the Intermediary did review and consider those additional records.

The Board notes that the Provider did not provide any analysis of the impact of the stated error rate on the cost report. The Board also notes that the direct cost of $56 per diem for a distinct part and $25 per diem for the nursing facility was not out of line for this type of facility. However, without proper documentation, the Intermediary was forced to utilize the average cost of the facility.

The Board concludes that the Provider failed to maintain adequate and verifiable documentation to support its allocation of nursing service costs to the Medicare distinct part and the non-Medicare

nursing facility. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, the Provider is required to maintain sufficient financial records and adequate cost data to assure the proper determination of costs under the Medicare program. The recordkeeping requirement includes the concept that data be accurate, maintained in sufficient detail to accomplish its intended purpose, and must be capable of verification by a qualified auditor. The Provider did not meet its obligations under this regulation.

DECISION:

The Board finds that the Provider's payroll system was not sufficient to support a proper cost allocation between the certified and non certified areas of the facility. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: May 29, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman