# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

2002-D25

**PROVIDER** –
Westside Nursing Center, Inc.
Greenville, South Carolina

Provider No. 42-5102

**vs.**

**INTERMEDIARY** –
Blue Cross and Blue Shield Association/
Palmetto Government Benefits
Administrator

**DATE OF HEARING**
October 17, 2001

Cost Reporting Period Ended -
September 30, 1997

**CASE NO.** 01-0200

**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:

Westside Nursing Center ("Provider") is a skilled nursing facility ("SNF") located in Greenville, South Carolina. The Provider is licensed for 132 beds of which a distinct part was certified for participation in the Medicare program. Palmetto Government Benefits Administrator ("Intermediary") commenced an on-site audit of the cost report for the period ending 9-30-97 in May of 1999. Pursuant to such audit, the Intermediary issued a Notice of Program Reimbursement ("NPR") on September 30, 2000, along with a final audit adjustment report. The Intermediary performed the entire on-site audit 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 time assignment to the Medicare certified distinct part ("CDP").

Based on the review of the two selected pay periods, the Intermediary combined all costs, charges and patient days, based on inadequate source documentation, and cited inequitable allocation of nursing service costs. The Board reviewed the Provider's request for a hearing and determined that it did have jurisdiction under the regulations at 42 C.F.R. §§ 405.1835-.1841. The amount of reimbursement in contention is approximately $282,940.

While the appeal was pending, the Provider reviewed additional payroll periods throughout the cost reporting period and submitted the comparisons to the Intermediary noting the variances between the time cards and the employee sign-in sheets. The Intermediary reviewed the additional documentation and determined that the new information was not sufficient to set up a distinct part area.

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 contends that the errors identified by the Intermediary were the results of minor errors and inconsistencies due to variances between the times entered on the sign-in sheets and the times recorded by the automatic clock. As an example, Employee A may have clocked in to work at 6:56 A.M., but signed in on the sign-in/out sheet at 7:07 A.M., a discrepancy of eleven minutes. As a result of the Intermediary's audit the Intermediary concluded that the numbers and percentages of errors were too high to allow the records to be used as a basis for substantiating nursing service cost allocation.

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 argues that the samples as designated and as administered by the Intermediary were not representative of the fiscal period in dispute. 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 designed 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 ("PMI"), Transmittal I-82, 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 was 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 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 § 2340.1.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

[1] See Exhibit P-13.

> 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 were, 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 it was denied reimbursement of its reasonable costs associated with the care and treatment of Medicare beneficiaries in a distinct part of a nursing home guaranteed by the regulation at 42 C.F.R. § 413.5. 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 Sign In 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 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) ¶ 38368 and the Board's use of 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, Medicare and Medicaid Guide (CCH) ¶ 38,216, aff'd, CMS Admin., September 27, 1989 Medicare and Medicaid Guide (CCH) ¶ 38,216 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 some 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 you 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 the 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 unit of the facility. 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 sign-in 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 sign-in 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 § 2340.1A 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 the time record reporting system which tied into the payroll system and that the payroll 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

[2] Tr. at 285.

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. For example, the Intermediary found that an employee's time card reflected 49.5 hours assigned to the CDP, when her sign-in sheet indicated only 29.5 hours were worked in the CDP, and 24 hours were reported to the NF. 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 additional pay periods further substantiates the inability of the Intermediary to rely on the Provider's time recording method. The Provider contends that the total percentage variances ranged from a negative 8.56% to a positive 2.65%. The Intermediary points out that while total variances according to the Provider's calculations may not be significant in certain pay periods, there are a substantial number of employees with significant variances between the time record report and the sign-in sheet. The Intermediary notes that the negative variances in hours between the time cards and the sign-in sheet are negated by the positive. This creates the overall effect that is much lower than if each employee is reviewed individually. Based on the Provider's summary, the variance in total hours reported between the time record report and the sign-in sheet is significant for numerous employees. The Intermediary contends that the variances between the time card report and sign-in sheet should be absolute and not taken as a whole to determine total percentage variances. The Provider calculated positive variances if the sign-in sheet is less than the time card report. Utilizing the Provider's calculations, the Intermediary contends that a variance in either direction substantiates the Intermediary's contention that the time card reports do not support the sign-in sheets (or vice versa).

The Intermediary argues that, based on the information in the preceding paragraph, the sign-in sheets consistently do not support the time card reports. Therefore, not only is the Intermediary unable to rely on the Provider's sign-in sheets and time card reports in total, the Intermediary is unable to verify that the Provider's record keeping system has the capability to accurately charge to the appropriate cost center.

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 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 an 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 are supported by the facts and authorities.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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| §§ 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):

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|---|---|---|
| § 2340 | - | Allocating Nursing Service Costs in Nursing Homes With Distinct Part Skilled Nursing Facility |
| § 2340.1A | - | 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 Association./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 LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented at the hearing, finds and concludes that the Intermediary properly combined all CDP and non CDP 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.

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 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 that is the basis for 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 did 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.A for guidance, which stresses equitable allocation of costs. Since the Intermediary found that the payroll records did not support the allocation of cost, the Intermediary is required to make an average cost adjustment to the cost report.

The Board finds that although many discrepancies between the time clock and the sign-in and out sheet were minor, the 8 hour time sheet is not a reliable source with which to allocate costs, because there were several large discrepancies on the sign-out sheets. These discrepancies include wrong room numbers, lack of sign-in or sign-out and employee allocations being ignored. Employees' own records showing time spent by employees in both distinct part and nursing facility were charged, in some instances, entirely to the distinct part.

Despite the in-service training of its employees in the use of the time cards, there was no evidence of any 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.

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 Provider's calculation of 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.

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 six additional time periods of its own choosing and the Intermediary did review and consider those additional records.

The Board concludes that the Provider failed to maintain adequate and verifiable documentation to support its allocation of nursing service costs between 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 qualified auditors. 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: June 17, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman