PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D7

PROVIDER –
Westview Manor
Derby, Kansas

Provider No. 17-5218

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
January 30, 2002

Cost Reporting Period Ended
December 31, 1998

CASE NO. 00-3976

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ISSUE:

Was the Intermediary's adjustment disallowing the allocation of general service costs to the ancillary cost centers proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Westview Manor ("Provider") is a skilled nursing facility located in Derby, Kansas. The facility is licensed for 120 beds, of which eight beds were certified as a distinct part for participation in the Title XVIII program. The Provider is managed by Liberty Healthcare Management Corporation, located in Naples, Florida. Mutual of Omaha ("Intermediary") desk reviewed the Provider's cost report for the period ended December 31, 1998 and submitted an adjustment report that included eliminating certain statistics from Worksheet B-1 relative to the allocation of indirect costs to certain ancillary departments. The Intermediary issued a Notice of Amount of Program Reimbursement ("NPR") on July 21, 2000.

The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") on September 19, 2000 and has met the jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835 - .1841. The Provider was represented by John Todd of JCT Consulting. The

Intermediary was represented by Thomas Bruce, Esquire, of the Mutual of Omaha Insurance Company. The amount of reimbursement in dispute is approximately $29,387.

PROVIDER'S CONTENTIONS:

The Provider asserts that its position is more accurately stated by stating the issue as follows:

> Did the Intermediary properly adjust the Provider's general service costs to the ancillary cost centers based on the lack of a clear and complete explanation as to the cause and reason for the disallowances and the Intermediary's inappropriate authority citation for the adjustment?

The Provider contends that both CMS Pub. 15-1 § 2306 and the regulation at 42 C.F.R. § 413.24 address the allocation of costs from general services (nonrevenue-producing) cost centers to other general service cost centers, and to ancillary (revenue-producing) cost centers, but neither prohibit the allocation of such costs. The regulation at 42 C.F.R. § 413.24 states in part:

"[a]ll costs of nonrevenue-producing centers are allocated to all centers which they serve . . .," and CMS Pub. 15-1 § 2306 describes the potentiality of such allocation and supports the allocation of the indirect costs as necessary to ensure full determinations for the purpose of the proper matching of expenses to support revenue. Section 2306 states: "[e]very nonrevenue-producing cost center has the potential of being allocated to every other nonrevenue-producing cost center in addition to revenue-producing cost centers."

The Provider contends that the Medicare regulation at 42 C.F.R. § 413.24, requires that the step-down method is the required cost finding method for skilled nursing facilities. This method utilizes apportionments of costs from nonrevenue-producing (general service) cost centers to other nonrevenue-producing cost centers and to revenue-producing (direct care and ancillary) cost centers for determining the full and reasonable costs of services provided. The regulation at 42 C.F.R. § 413.24(d)(1) states:

> Step-down Method. This method recognizes that services furnished by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue -producing centers. All costs of nonrevenue-producing centers are allocated to all centers they serve, regardless of whether or not these centers produce revenue.

The Provider points out that the program instructions at CMS Pub. 15-1 § 2306 expand on the regulation as follows:

> for the purpose of proper matching of revenue and expenses, the cost of the revenue-producing centers should include both its direct expenses and its proportionate share of the costs of each revenue-producing center (indirect costs) based on the amount of services received.

The Provider also maintains that the allocation of general service costs to other departments, including ancillary departments, is further supported by the provisions that providers are to be paid their reasonable costs for services provided, as set forth in 42 C.F.R. § 413.9, which states in part:

> (a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary

> and proper costs incurred in furnishing the services.

and continues in identifying reasonable cost:

> (b) Definitions - (1) Reasonable cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." The regulations in this part take into account both direct and indirect costs of providers of services.
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> (c) (3) The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, . . . It includes both direct and indirect costs.

The Provider contends that the Intermediary did not provide an explanation or appropriate reference for any of the adjustments at issue. The Intermediary's narratives consisted of either: "to remove (identified cost centers) overhead from the ancillary centers" or "'to be consistent with prior year."[1] These statements of intent are not explanations of justifiable causes or reasons for implementing the adjustments.

The Provider argues that the services provided to the ancillary departments by the affected general service departments are services relative to the departments providing the services that are beneficial to the receiving departments, i.e., services-in-kind. A description of some of the services provided by the Nursing Administration and the Social Service Departments can be found in correspondence to the Intermediary.[2]

The Provider points out that the Intermediary stated in other documentation that with respect to the Nursing Administration Department, the services provided to ancillary departments, such as "observation" and "chart review," were incidental, at best, and are commonly identified as normal routine nursing care. The Provider argues that the services provided by the

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[1] Tr. at 18-19 and 28-29.

[2] Tr. at 33-34, 87-93, 108-112 and 114-116.

Housekeeping Department, such as cleaning a toilet or mopping a floor, are as well "incidental" and commonly identified as routine housekeeping. Yet the Intermediary allows such allocation without objection and recognizes such as a "service-in-kind."

The Provider argues that it could be interpreted that because the General Service department did not engage directly in the provision of the rehabilitation therapies, the allocation of the department's cost was inappropriate and not justified. However, neither CMS Pub. 15-1 nor the regulations state that the service must be directly related to the services provided by the other department, but imply that the service relates to the services provided by the general service department, i.e. services-in-kind, such as laundry or housekeeping services.

The Provider points out that the Board has previously affirmed the allocation of costs for the provision of services-in-kind from general service areas to the ancillary departments. Saint Mary's Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 91-D32, April 2, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,155 (St. Mary's). In that decision the Board found "the costs of the Provider's medical records department should be allocated to all inpatient routine and ancillary service departments . . ." Id at ¶ 39,155. The Board based these findings on a determination that the ancillary departments receive services from the medical records department along with the routine departments. The Board also cited the definition of the step-down method of cost finding found in 42 C.F.R. § 413.24 et seq., which states, "all costs of nonrevenue-producing centers are allocated to all centers that they service, regardless of whether or not these centers produce revenue."

While medical records cost is not one of the cost allocations that is at issue in this dispute, the parallels are evident and consequential in the Board's description of its findings for the basis of its decision and in its considerations relative to this appeal. The basis for the Board's decision implies that the Medical Records Department provides services related to medical records and are "services-in-kind" offered by a general service department.

The Provider points out that in another decision related to the allocation of costs from a general service cost center to ancillary cost centers, with specificity to the Nursing Administration Department, the Board substantiates the incidence of the allocation of indirect costs as being typical and routine. In Sharp Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California PRRB Dec. No. 92-D27, Jan. 21, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,172 ('Sharp"), the costs of the general service (non-revenue producing) centers being allocated to ancillary (revenue-producing) departments are justifiable and allowable. The decision is based on the provider's reclassification of costs for salaries and benefits for nursing

supervisors from the routine services area to the Nursing Administration cost center and the intermediary's adjustment reclassifying the costs back to the routine services area. A significant parallel to the instasnt case is clearly implicit in the Board's reasoning.

The Provider maintains that in its ruling in Sharp, the Board stated that: "[r]eclassifying the supervisors' hours from routine areas to nursing administration would result in those costs being allocated to ancillary departments . . ." Id at 40,172. The Provider argues that this clearly implies and affirms a justification for, and the acceptability of, the allocation of costs from the Nursing Administration cost center to ancillary departments.

The Provider contends that in Sharp, the Board suggested in its reasoning that the provider had allocated nursing administration cost to the ancillary departments, and the intermediary apparently determined that such allocations were justified and acceptable. This conjecture is supported by the failure of the intermediary to make adjustments to reverse the "suggested" cost allocations of Nursing Administration costs to the ancillary departments. The Provider argues that the parallels are evident. The Nursing Administration department is a general service department providing services to other departments, including ancillary departments, and the allocation for these indirect costs is justifiable and allowable.

The Provider contends that the Intermediary made an uninformed and random assumption when it adjusted the allocated Central Supply costs to the Inhalation Therapy Department. The Intermediary contend that it made the adjustment because the sampled invoices for a provider in the chain showed that the contracted company provides its own supplies. The implication is that the respiratory therapy supplier which contracted with the other provider in the chain is also contracted with the instant Provider.

The Provider contends that it contracted with the Inhalation Therapy department of a local hospital which is not under contract with any related provider. Had the Intermediary reviewed Worksheets ("W/Ss") A-8-4 and A-8-5 for Respiratory Therapy, it would have noted that there are no cost entries for supplies on Lines 43 and 62 of the respective W/Ss.

The Respiratory Therapy Department obtains routine medical, nursing and pharmaceutical supplies from the Provider's Central Supply and Pharmacy departments. These include such items as gloves and oxygen tubing from the

Central Supply cost center and sterile water and lubricants from the Pharmacy cost center.

INTERMEDIARY'S CONTENTIONS

The Intermediary contends that the Provider has not demonstrated that any services were provided to the ancillary cost centers by either the Nursing Administration department or the Social Service department. Even if they could present such evidence for argumentative purposes, it can not be quantified in such a way as to allocate these costs down to the ancillary cost centers. Therefore, the statistical basis claimed by the Provider results in a miscalculation of costs.

The Intermediary maintains that the Medicare regulations at 42 C.F.R. § 413.20 require: "that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program . . . ." and that they must be "capable of verification by a qualified auditor . . . ." The regulations at 42 C.F.R. § 413.24 describe the cost finding methodology, including the step-down method of allocating non-revenue generating cost centers to all cost centers they serve. Cost report instructions provide the recommended and acceptable statistics for implementation of the step-down methodology. CMS Pub. 15-1 § 2313. The Provider's allocation did not adhere to the aforementioned regulations and/or Program policy by failing to adequately document the services rendered and by failing to meet the criteria required of periodic time studies.

The Intermediary asserts that the Provider's time studies do not meet the Program requirements. The time studies in question covered just one week per quarter. According to CMS Pub. 15-1 § 2313.2E: "[a] minimally acceptable time study must encompass at least one full week per month of the cost reporting period . . . ." Moreover, the time studies were not signed and/or dated. In some instances, the time studies were clearly filled out by the same person (similar handwriting) even though they pertained to different individuals. The Intermediary does not believe the individuals to which the time studies relate actually completed the time studies. There is no narrative backup behind the time studies and little, if any, description as to what was happening. The Intermediary was unable to relate the statistics on the time studies to the four quarters on the cost report. Therefore, the time studies were not auditable documentation.

The Intermediary argues that the Provider's presentation in its supplemental position paper and at the hearing was an attempt to shift the burden of proof to the Intermediary through exhaustive scrutiny of the Intermediary's narrative

explanations in its adjustments as well as the policy citations; alleging that the explanations were inadequate and the citations were improper. The

Intermediary was questioning what services, if any, were actually provided to the ancillary departments through conversations with the auditor.[3]

The Intermediary points out that at the hearing the Provider's representative stated "this accumulation of time comes from daily time sheets, which were . . . maintained, but they've since been lost?"[4] The Intermediary argues that those disclosures solidify its argument that the time studies were not reliable documentation.

The Intermediary points out that the Provider's witness, when asked what she would call services-in-kind, responded: "a support service, most (sic) for coordination or a liaison role . . . ." [5] Also, the witness, when asked by the Intermediary whether benefits are flowing back from the ancillary areas, testified: "that's entirely true . . . ."[6] This confirms the fact that it's a two-way street when it comes to benefits flowing back and forth between departments in the nursing home. Furthermore, the witness, when asked by the Intermediary if she observed the completion of the time studies and/or got involved with them at all, replied: "not routinely . . . ."[7] Therefore, the Intermediary argues that the testimony offered by the witness weakened the Provider's argument that the so-called services moved only in one direction, i.e., to the ancillary cost centers. In addition, the witness could not truly attest to the authenticity of the time studies.

The Intermediary contends that the activity taking place between the general service cost centers and the ancillary cost centers was in reality the coordination of the care plan to be given to the residents; not a support service as implied by the Provider. As a result, the allocation of general service costs down to the ancillary cost centers was not warranted.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS

1. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.20	-	Financial Data and Report

[3] Tr. at 33.
[4] Tr. at 94.
[5] Tr. at 95-96.
[6] Tr. at 114.
[7] Tr. at 118.

§ 413.24 et seq. - Adequate Cost Data and Cost Finding

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

§ 2306 - Cost Finding Methods

§ 2313 et seq. - Changing Bases for Allocating Cost Centers or Order in Which Cost Centers are Allocated

3. Case Law:

Saint Mary's Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 91-D32, April 2, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,155.

Sharp Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 92-D27,

January 21, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,172.

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 adjusted the Provider's general service costs.

We reject the Providers position that it is entitled to payment if the Intermediary failed to state adequate reasons or proper citations of authority for the adjustments. Without deciding whether the Intermediary's rationale was sufficiently stated, the Board has authority to reverse adjustments only where a provider demonstrates entitlement to Medicare payment, not as a sanction against the Intermediary.

The Board finds that the Provider did not present adequate documentation to properly allocate the Nursing Administration and Social Services costs. The Medicare regulation at 42 C.F.R. § 413.20 requires: "that providers maintain sufficient financial records and statistical data for proper determination of costs

payable under the Program . . . ." and that they must be "capable of verification by a qualified auditor . . . ." The Medicare regulation, 42 C.F.R. § 413.24, describes the cost finding methodology, including the step-down method of allocating non-revenue generating cost centers to all cost centers they serve. The

cost report instructions at CMS Pub. 15-1 § 2313, also provide the recommended and acceptable statistics for implementation of the step-down methodolgy. The Board finds that the Provider's allocation did not adhere to the aforementioned regulations and program policy by failing to adequately document the services rendered and by failing to meet the criteria required for periodic time studies.

The Provider submitted time studies for only one week per quarter. According to CMS Pub. 15-1 § 2313.2E: "[a] minimally accepable time study must encompass at least one full week per month of the cost reporting period . . . ." The Board also finds that the time studies were not signed or dated. In some instances the time studies appear to have been completed by the same individual even though they pertained to different individuals. Testimony at the hearing revealed that the back-up for the time studies was lost or misplaced and it was not available for the Intermediary's audit.

The Board finds that the Provider did submit position descriptions that appear to justify the time spent in the ancillary department. However, the time studies do not authenticate the time spent or that the job functions were actually carried out. The Board also agrees with the Intermediary's findings that the individual timesheets do not add up to the total time claimed by the Provider. The Provider was given ample opportunity to submit additional documentation but did not do so.

The Board finds the testimony of the Provider's witness was credible and that the Nursing Administration and the Social Service Departments played an important role in the facility. However, the documentation to support the Provider's contentions was not available. The Provider mentioned two cases Saint Mary's and Sharp Memorial, which it believed strengthened its position. However, the Board finds that the two cases are not on point and disregarded them in its decision.

DECISION AND ORDER:

The Intermediary's adjustment reclassifying the Nursing Admninistration and Social Services cost centers was proper. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTCIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary Blodgett, D.D.S

DATE OF DECISION: December 19, 2002

FOR THE BOARD

Suzanne Cochran
Chairperson