PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D45

PROVIDER –
Angeles Home Health Care, Inc.
Los Angeles, California

Provider No. 05-7252

vs.

INTERMEDIARY –
Blue Cross Blue Shield
Association/United Government Services,
LLC - CA

DATE OF HEARING -
May 29, 2003

Cost Reporting Period Ended
July 31, 1996

CASE NO. 99-0722

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ISSUE:

Whether the Intermediary's adjustments of Medicare visits to agree with Medicare's Provider Statistical and Reimbursement (PS&R) report were proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Medicare program accounts for each home health agency provider's visits based on billings made by the provider to Medicare. Each fiscal year Medicare issues a statistical report, the PS&R report, that provides pertinent data about Medicare visits. Each provider is responsible for accounting for all of its visits, including Medicare visits. The reconciliation of a provider's records with the PS&R report is generally done during the Medicare cost report settlement process. The issue in this case concerns this reconciliation and the resulting treatment of the variance between the Provider's record of visits with those reported on the PS&R.

Angeles Home Health Care, Inc. (Provider) claimed 91,156 Medicare visits on its fiscal year ended July 31, 1996 cost report. Subsequently, on August 6, 2001, United Government Services, LLC, (Intermediary) forwarded an updated PS&R report to the Provider. The Intermediary adjusted the "as filed" Medicare visits to agree with the PS&R report and ultimately disallowed 402 denied Medicare visits that had been denied for Medicare payment. The Intermediary reclassified these denied visits to the "other" visits category, thus leaving them in the total visit count. The Intermediary's adjustments resulted in a reduction in Medicare reimbursement of approximately $33,000.

The Provider appealed these adjustments to the Provider Reimbursement Review Board (Board). The appeal has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider was represented by Mark S. Kennedy, P.C., Attorney at Law. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary has incorrectly reclassified denied visits for Medicare patients and placed them in the "other" visits category. In doing so, the Provider claims the Intermediary improperly shifted direct Medicare and full overhead costs to other payors. To avoid this illegal shifting of cost, the denied Medicare visits should be eliminated completely and removed from the cost report.

The Provider contends that under the Medicare program, a billable (and therefore reportable) visit is one in which the services are applicable to patient care and can be billed to the party reasonably expected to pay the invoice. If the Intermediary deems that a visit was unnecessary or unreimbursable, such as the 402 visits in the instant case, the Provider cannot bill the patient or another carrier for the service. The cost of the visit becomes a general cost of doing business, similar to an administrative visit, and would be properly accounted for by eliminating the visit from the total visit count. This proportionately distributes the cost to all payors. Additionally,

the Provider pays its nursing staff on a salaried basis, and therefore, no additional cost was incurred for any visits subsequently disallowed by a retrospective Intermediary review.[1]

The Provider notes that the Intermediary's adjustments assume that the Provider has no ability to track the visits performed by "payor source," yet it accepts total visits as being correctly reported. The schedule and charts attached as Exhibit "B" to the affidavit[2] demonstrate the significance of the adjustments relative to the volume of visits actually performed.[3] The adjustments assume that the Provider, while being 100% correct relative to total visits, was off by 33.51% in summarizing "other" visits. Contrary to this assumption, however, the Provider has a sophisticated computer system that correctly tracks and accounts for Medicare and "other" visits.[4]

The Provider contends that home care providers must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. See, 42 C.F.R. § 413.53(a)(3). Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. Thus, it is essential that the ratio between Medicare and non-Medicare visits be properly determined so that cost can be apportioned between these two categories. Before costs can be apportioned, there must first be an accurate visit count apportioned equitably to Medicare beneficiaries and "other" or non-Medicare beneficiaries. A visit is defined under the regulations to be:

> [a]n episode of personal contact with the beneficiary by staff of the HHA or others under arrangements with the HHA, for the purpose of providing a covered service.

42 C.F.R. § 409.48(c).

This term has been interpreted broadly by the Board, and it has been held that it is not necessary for an episode of personal contact with a patient to be reimbursable in order to be judged a visit. Nevertheless, the Provider contends that the language above, read plainly, clearly implies that a visit necessitates a covered service. Any other reading of this language is unduly tortuous and appears to clearly be disadvantageous to the provider. See Visiting Nursing Association of Western New York, Inc. v. Blue Cross Blue Shield Association, Blue Cross of Western New York/Empire Blue Cross, PRRB Decision No. 91-D23, February 6, 1991, Medicare & Medicaid Guide (CCH) ¶ 39077, decl'd rev. HCFA Administrator, March 26, 1991.

The Provider notes that the Board in Maxicare, Inc. v. Blue Cross Blue Shield Association/Palmetto Government Benefits Administrators, PRRB Decision No. 2000-D55, May 30, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,501(Maxicare) stated that the term "visit" was interpreted broadly by the Board where it was held that it is not necessary for an episode of personal contact with a patient to be reimbursable in order to be judged a visit. In that case, the Board included the cost of 549 self-disallowed visits in the cost report over the provider's

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[1] See Provider Exhibit P-1.
[2] Id.
[3] Id.
[4] Id.

objection because the episodes of patient contact were determined to be "visits" even though they were not reimbursable. Even though the Intermediary has informed the Provider that it believes Maxicare is dispositive on this issue and asserts the 402 visits must be included in the 1996 cost report, the Provider submits that reclassifying denied Medicare visits and placing them in the "other" visits category skews apportionment of cost in favor of Medicare, and illegally shifts costs to non-Medicare payors.

The Provider observes that, unlike Maxicare, where the Provider "self-disallowed" visits that exceeded the number prescribed in the physician's plan of care because they would not be covered services, the visits reclassified by the Intermediary in the instant matter were compliant with the treatment plan and physician orders. However, in neither situation should the visits be counted in the "other" visits category to determine proper cost finding.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not furnish sufficient information and documentation to support its argument pursuant to 42 C.F.R. §§ 413.20 and 413.24 and HCFA Pub 15-1 §§ 2300, 2304ff and 2402.2. The referenced Medicare regulations and instructions explicitly require the Provider to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare Program. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, auditable, and in sufficient detail to accomplish the intended purpose.

The Intermediary contends that for it to resolve this issue favorably to the Provider, the Provider must submit the following items:

1) Reconciliation of the Provider's records to the PS&R (showing variance).
2) UB-92s and Medicare Remittance Advices

The Intermediary notes that it used the PS&R in accordance with HCFA Pub. 13-2 §§ 2241 and 2243. The PS&R served as the best available source of Medicare settlement data for purposes of:

- Apportioning the allowable costs of services to beneficiaries, pursuant to 42 C.F.R. §§ 413.50 and 413.64, and
- Determining Medicare Program payments, pursuant to 42 U.S.C. §§ 1395f(b) and 1395(g), 42 C.F.R. §§ 413.60 and 413.64, and HCFA Pub. 15-1 § 2400.

The PS&R showed a reliable detail of Medicare claims which the Provider and the Intermediary have processed for Program payment. The Provider did not furnish any evidence that the PS&R was inaccurate, erroneous or unacceptable for cost reporting purposes pursuant to the referenced Program instructions.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, parties' contentions and evidence submitted, finds and concludes that the Intermediary properly used the PS&R report and reclassified denied Medicare visits as "other" visits that were used in apportioning costs to Medicare.

The Board finds the Provider's interpretation of 42 C.F.R. § 409.48(c) to be very narrow. The denied Medicare visits could mean that the visits were for covered services. There can be various reasons why visits could be denied; e.g., benefits had been exhausted. In such instances there still could be a covered service involved. Denial of a Medicare visit does not automatically make that visit a noncovered service that should be eliminated from the visit count. Furthermore, the Provider did not offer any documentation as to what the denied visits were for. Thus, the Board could not determine if visits could have been eliminated from the total visit calculation.

The Provider also argues that if the denied Medicare visits were not eliminated from the "other" visit category, then an inappropriate cost shifting to the program would result. The Board finds this argument unpersuasive. The Provider had a 98% Medicare utilization. Regardless of whether "other" visits are included or excluded in the total visit count, all costs would essentially be charged to Medicare based on its overwhelming share of services provided to patients.

The Board further finds that the total visit count was undisputed. The disputed visits were for Medicare beneficiaries, and they were denied by the Intermediary. Finally, the Board finds that the Board decisions cited by the Provider to support its position are not relevant to this case.

Based on the above, the Board concludes that the Intermediary properly determined Medicare visits based on the PS&R report and included denied Medicare visits in both the "other" and the total visit categories.

DECISION AND ORDER:

The denied Medicare visits are included in "other" and total visit categories for apportioning costs to the Medicare Program. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Gary B. Blodgett, DDS
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

BOARD MEMBERS NOT PARTICIPATING:

Suzanne Cochran, Esquire

Board Member Cochran has recused herself from this case under 42 C.F.R. § 405.1847.

DATE: August 21, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman