PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D54

PROVIDER –
Pleasant Care – San Joaquin
Bakersfield, CA

Provider No. 05-6323

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
September 25, 2002

Cost Reporting Period Ended
March 31, 1999

CASE NO. 01-2453

INDEX

ISSUE:

Was the Intermediary's adjustment reclassifying Medical Director cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pleasant Care – San Joaquin ("Provider") is a 237-bed Medicare certified Skilled Nursing Facility ("SNF"), located in Bakersfield, California. Mutual of Omaha ("Intermediary") is the Provider's Intermediary. On September 27, 2000, the Intermediary issued a Notice of Program Reimbursement ("NPR") which removed the Utilization Review ("UR") cost from direct reimbursement and added the cost to the Administrative and General ("A&G") cost center. Direct costs are those attributable to furnishing Medicare services only as opposed to services to the patient population generally. Direct costs are paid entirely by Medicare. Placing the cost in A&G spreads the cost among all patients. The effect of that adjustment was to materially reduce the amount of Medicare reimbursement due the Provider. The Provider disagreed with the Intermediary's adjustment and timely appealed to the Provider Reimbursement Review Board ("Board"). The Provider's request met the jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835-.1841. The amount of Medicare reimbursement under contention is approximately $7,200.

The Provider was represented at the hearing by Paul Gulbrandson, C.P.A., and the Intermediary was represented by Tom Bruce, C.P.A.

PROVIDER'S CONTENTIONS:

The Provider contends that the Medical Director's fees in dispute were related to the UR process and therefore were properly categorized as filed. The Provider further contends that UR is a Medicare-only process and therefore should be fully reimbursable by Medicare. The Provider also made the following contentions:

a. The Intermediary did not submit one iota of documentation with the related NPRs.
b. The Intermediary actually performed an audit, but did not perform it properly.
c. The Provider contends that it does not have to prove allowability until the Intermediary looks at the Provider's documentation.
d. The Intermediary's requests for documentation were too burdensome.
e. It is more economical for the Provider to travel to Baltimore than to provide photocopies of relevant documentation for two facilities.[1]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not established the allowability of the Medical Director's UR expense as a direct cost on the Medicare Settlement Worksheet, in accordance

[1] Provider's post-hearing position paper at 13-16.

with the cost reporting instructions at CMS Pub. 15-II §§ 3519 and 3534.1. These instructions specify that:

> [i]f the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician cost among all patients using the SNF.

The Intermediary argues that the Provider did not adequately document direct cost treatment. The regulation at 42 C.F.R. § 413.24 states in part that: "[p]roviders receiving payment on the basis of reasonable cost must provide adequate cost data." The Intermediary points out that the Provider's representative confirmed that it is the Provider's responsibility to document that the expense should receive direct cost treatment.[2]

The Intermediary points out that it attempted to obtain the source documentation from the Provider to substantiate the allowability of the claimed expense. It requested additional information by letter, including follow up letters, by discovery, and by telephone. However, the Intermediary never received the information. The Provider's witness had also previously acknowledged that he wasn't entirely confident that the records available would support the treatment requested on the as-filed cost report. In response to the Intermediary's July 15, 1998 letter requesting additional information, the Provider witness responded, "These costs represent the fees paid to physicians primarily for utilization review purposes. Unfortunately, I must admit that some of the facilities do not keep complete records of UR meetings."[3]

The Intermediary contends that its adjustment was appropriate in light of the Provider's unwillingness and/or inability to provide the documentation necessary to demonstrate the allowability of the expense.[4] Based upon the lack of documentation, the Intermediary removed the UR costs from the direct reimbursement line and added them back to the A&G cost center, in accordance with the cost reporting instructions at CMS Pub. 15-II §3519.

The Intermediary argues that based upon the evidence presented by the Provider to the Intermediary to support the categorization of the Medical Director's UR expense, the Provider did not substantiate that the expense qualified for direct reimbursement.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions and evidence presented, finds and concludes that the adjustment made by the Intermediary to the Medical Director's UR costs was proper.

The Provider has taken the position that the Intermediary did not come to the Provider facility to perform an on-site audit, and therefore the Provider does not have the responsibility to prove its claimed costs are allowable. The Provider's witness testified that:

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[2] Tr. at 155:3 – 155:11.
[3] Exhibit I-10, Tr. at 155:24 –156:9.
[4] Tr. at 156:18 –158:18.

> [T]he way an audit works is the cost report is filed, the Intermediary comes in and the Intermediary looks at the documentation to prove that it is not allowable. The Provider doesn't have to prove it's allowable"[5]

The Provider relies on the "Yellow Book," the Intermediary's audit guidelines, in support of its position although it failed to make any reference to specific procedures or techniques it claims were violated. The Board finds that the audit guidelines do not shift the burden of proof to the Intermediary.

The Board finds that the Provider was not in compliance with the Medicare regulation at 42 C.F.R. § 413.24 - Adequate Cost Data and Cost Finding. That regulation states in part:

> (a) *Principal*. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data.
>
> * * * * *
>
> (c) *Adequacy of Cost Information*. Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

The Board finds that the Intermediary made several attempts to obtain the necessary documentation. This was done prior to the finalization of the NPR as well as shortly before the hearing. The Provider did not respond and did not present documentation at the hearing to support its position.

The Provider's witness, employed as the Provider's Director of Reimbursement,[6] testified that "it was his understanding" that utilization review by medical personnel was conducted only for Medicare patients.[7] He represented that the records requested would have been "burdensome" to copy and send to the Intermediary but that if the Intermediary had come to the Provider's facility to audit, they would have been furnished at least a sample of records to support the Provider's position. He also acknowledged that the Intermediary indicated that a sampling might be sufficient. However, when the Intermediary did not get back to him to specify records for a sampling, the Provider did not furnish any documentation whatsoever of utilization review records to the Intermediary[8] nor did the Provider furnish any support to the Board for its position. We also note the Provider witness's correspondence to the Intermediary in which he stated: "Unfortunately, I must admit that some of the facilities do not keep complete records of UR meetings."[9]

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[5] Tr. at 133:11.
[6] Tr. at 37:18
[7] Tr. at 145:10-146:20.
[8] Tr. at 150:1-154:1.
[9] Tr. at 155:24-156:9.

DECISION AND ORDER:

The Intermediary's adjustment of the Provider's Medical Director's cost (UR) was proper due to a lack of documentation. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Gary D. Blodgett, DDS
Martin W. Hoover, Jr., Esq.

DATE: August 28, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman