PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D60

PROVIDER –
West Valley Home Health, Inc.
West Valley, Utah

Provider No. 46-7051

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/ Cahaba Government Benefit Administrators

DATE OF HEARING -
June 19, 2003

Cost Reporting Period Ended
December 31, 1997

CASE NO. 00-0064

INDEX

ISSUES:

1. Was the Intermediary's adjustment to home office costs proper?

2. Was the Intermediary's adjustment disallowing a portion of the auto allowance proper?

3. Was the Intermediary's adjustment to travel and lodging costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

West Valley Home Health, Inc. (Provider) is a freestanding, privately held home health agency located in West Valley, Utah. Cahaba Government Benefit Administrators, Inc., (Intermediary), is an intermediary under contract to the Centers for Medicare and Medicaid Services (CMS) to administer the Medicare Program for the Provider.

This case involves the Provider's challenge to three of the Intermediary's adjustments to its claimed costs for fiscal year ending December 31, 1997: removal of home office costs; removal of non-allowable lodging expenses; and removal of auto expenses.

The Provider filed its appeal to the Provider Reimbursement Review Board (Board), and the filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider is represented by Lucian Bernard, Esquire, of Pearson & Bernard, P.S.C. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue No. 1 – Home Office Costs

Facts:

On January 1, 1995, 100% of the stock of West Valley was acquired by Medicare Training & Consulting, Inc. (MTC). MTC is a wholly owned and operated by James Plonsey, MTC's President. It is a Subchapter S corporation located in Lansing, Illinois and is a healthcare consulting firm which prepares cost reports for various clients, including home health care agencies, hospitals, rural clinics and skilled nursing facilities. Other services offered by MTC to its clients include general advice about the Medicare program, acquisitions and negotiations, as well as seminars on various aspects of the industry.[1]

During 1997, MTC employed three consultants to perform services on behalf of MTC to its clients throughout the United States.[2] These clients included 41 home health agencies, 15 hospitals, 5 physical therapy clinics and 5 rural health clinics.[3] The costs associated

[1] See, Provider Exhibits P-2 and P-3.
[2] See, Provider Exhibit P-3.
[3] Id.

only with the activities of MTC were segregated from those which were shared expenses of both the Provider and MTC.

The Intermediary conducted a desk audit of the Provider's 1997 cost report which included a review of home office costs. It disallowed the Provider's claimed costs for several reasons. First, there was only one health care facility that received an allocation of home office cost. Second, the schedule of cost submitted by the Provider did not agree with the cost claimed on the Home Office Cost Statement (HOCS), and the Provider's response to the Intermediary's query failed to resolve the variances. Third, there was no supporting documentation for the allocation statistics used by MTC to allocate cost to the Provider. Finally, the Intermediary determined that the HOCS was not the best method of allocating cost from MTC to the Provider.[4] Instead , the Intermediary adjusted the allocation of cost based on the time spent by Mr. Plonsey on work performed for the Provider.[5] The Intermediary issued a Notice of Program Reimbursement dated September 23, 1999, implementing its adjustment which resulted in a reduction in Medicare reimbursement of approximately $62,000.

In 1998, MTC received a HOCS provider number. The 1998 and 1999 cost reports were settled using the pooled allocation method used by the Provider in 1997.[6] The Provider's HOCS provider number is 44-H104, and its designated home office intermediary is Riverbend Government Benefit Administrators.

PROVIDER'S CONTENTIONS:

The Provider contends that the Medicare Program requires CMS to assure that payments to cost-reimbursed providers are both reasonable and necessary to the delivery of health care services. 42 U.S.C. § 1395(v)(1)(A). As noted in the regulations, payments to providers are to reflect the actual costs of services however widely the costs vary from provider to provider and from time to time. 42 C.F.R. § 413.9(c)(3). Further, under Medicare regulation, the Intermediary must provide support for any proposed adjustments to a provider's as-filed cost report by providing a rationale in the Notice of Program Reimbursement.[7] Similarly, providers are required to support any and all claimed costs with adequate cost data. 42 C.F.R. § 413.24.

The Provider notes that it submitted a HOCS for 1997 which was rejected by the Intermediary. The basis for the rejection was that the Provider was the only health care provider in the chain. The Provider used the pooled allocation method as outlined in HCFA Pub. 15-1 § 2150.3.D.2. The Provider contends that the Intermediary cannot take the position that the Provider did not properly employ the pooled allocation method. Instead, the Intermediary disallowed $62,855 of costs allocated to the Provider by substituting the direct hours worked by the Provider's owner, Mr. James Plonsey, divided

[4] See, Intermediary's position paper, pp. 9-10.
[5] See, Provider Exhibits P-2- P-10. Id.
[6] See, Provider Exhibits P-1-P-10. Id.
[7] See, Provider Position Paper, p.7.

by total hours billed and then multiplied by the net shared expenses reported by the Provider.

The Provider observes that the Provider Reimbursement Manual acknowledges the appropriateness of a home office under the circumstances in this case. "For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity which are owned, leased, or through any other device, controlled by one organization." HCFA Pub. 15-2 § 1000 (emphasis added). See also HCFA Pub. 15-1 § 2150.

The Provider argues that there is no statutory or regulatory support for the Intermediary's position that there must be at least two health care providers to constitute a chain organization subject to home office cost reporting standards and that the Intermediary's position is in direct contradiction of HCFA Pub. 15-2 §1000. In addition, the Intermediary is creating additional requirements for home office status that are not contained in either the statute or the regulations. See, Maximum Home Health Care, Inc. v. Shalala, 272 F.3d 318 (6th Cir. 2001).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the audit adjustment to disallow home office costs was made in accordance with the provisions of Medicare regulations at 42 C.F.R §§ 413.9, 413.20 and 413.24, and HCFA Pub. 15-1 § 2150. The Provider's failure to support its submitted costs and statistics on the HOCS does not meet the record-keeping requirements of Medicare regulations at 42 C.F.R. §§ 413.20 and 413.24.

HCFA Pub. 15-1 § 2150 defines a chain organization as:

> a group of two or more health care facilities which are owned, leased, or through any other devise, controlled by one organization. (emphasis added).

The submitted HOCS allocated cost to the Provider and to MTC. Since MTC is considered to be the home office in this case, this method causes the home office to allocate costs to itself. This is not the intention of an HOCS. According to HCFA Pub. 15-1 § 2150.3.A, the purpose is to allocate costs to the components of the home office.

The Intermediary observes that the objective for determining reasonable cost, according to 42 C.F.R. § 413.9 is ". . . the costs with respect to individuals not so covered will not be borne by the program." It is the Intermediary's position that MTC is attempting to allocate costs associated with work performed for other entities to the Provider.

The Intermediary argues that it has calculated MTC's cost associated with work performed for the Provider in Intermediary Exhibit I-12. This method is based on the number of hours worked for the Provider in proportion to the total hours worked. This

allows for a fair method of allocating cost which meets the guidelines described in 42 C.F.R. § 413.9.

Issue No. 2 – Auto Allowance

Facts:

The Provider reimbursed the administrator and nursing administrator an auto allowance for the use of their personal automobiles. The total expense claimed on the Medicare cost report was $2,623.

The Intermediary obtained the Provider's mileage logs, which supported a total of 2,001 miles for the nursing administrator. Based on a mileage allowance of $.315 per mile, the Intermediary allowed $630. Since the nurse administrator received a $2,200 allowance, it disallowed $1,570 of her claimed costs. The administrator did not maintain mileage logs and claimed 719 miles to attend a conference. At $.315 per mile the Intermediary allowed $226 and disallowed $197 of his total allowance of $423. These adjustments resulted in a reduction in Medicare reimbursement of approximately $2,000.

PROVIDER'S CONTENTIONS:

The Provider contends that its administrator and nursing administrator were given an auto allowance for use of their personal auto for agency business. The nursing administrator, in addition to being the Provider's director of nursing, was also required to be on call and she performed skilled nursing visits. She kept a log of the miles related to patient visits which totaled 2,001.[8] The Intermediary allowed a rate of $.315 per mile, which is the IRS guideline, times the 2,001 miles driven, allowing $630 in costs. However, the Intermediary failed to consider HCFA Pub.15-1 § 2114.1, which allows compensation paid to a non-owner employee to be considered part of that employee's compensation. This position is supported by River Valley Home Health Agency, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Georgia/Columbus, Inc., PRRB Dec. No. 84-D78, February 29, 1984, Medicare and Medicaid Guide (CCH) ¶ 33,931. In that case, the provider paid a travel allowance of $200 per month. Since there was no mileage log submitted, the intermediary considered these amounts as compensation. The Board found executives' automobile costs should be classified as compensation. Therefore, the Provider contends that the amounts above the IRS allowance should be considered part of the employees' compensation. Since the Intermediary made no adjustment to the compensation of the key employees, these additional amounts should be allowable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the audit adjustment which disallowed a portion of the auto allowance was made in accordance with the provisions of Medicare regulations 42 C.F.R. §§ 413.9, 413.20 and 413.24 and HCFA Pub.15-1 §§ 2105.6, 2102, 2114.2 and 2304. It is the Intermediary's position that the Provider bears the burden of establishing

[8] See, Provider Exhibit P-5.

that they had the necessary documentation to support the transportation reimbursement, and that it was related to patient care. The Provider has failed to supply actual auditable support and, therefore, has not complied with the necessary documentation requirements.

Issue No. 3 - Travel Costs

Facts:

The Provider submitted $6,480 of travel and lodging expense on the as-filed Medicare cost report. The Intermediary reviewed the invoices supporting these expenses and found the following to be non-allowable:

Invoice Date	Description and Purpose of Expense	Expense Adjusted
8/23/97	American Airlines – Mr. Plonsey's travel from Florida to Illinois	$ 177
9/23/97	Hyatt Regency-Dallas – Mr. Plonsey's hotel cost for attending Texas Association of Home Care	$ 566
10/23/97	Sheraton Hotels-Boston – Mr. Plonsey's hotel cost for attending National Association for Home Care (NAHC) Conference	$ 773
Total		$ 1,516

PROVIDER'S CONTENTIONS:

The Provider contends that it is only claiming the costs of attending the NAHC annual convention in Boston, Massachusetts in October, 1997 as costs related to patient care. The only cost claimed was $773 for the hotel. The Provider did not claim conference fees, airfare or meals. The Provider did benefit from the information disseminated at the conference, and this information was conveyed to the agency personnel. The Provider acted in a prudent manner as required by HCFA Pub. 15-1 § 2103, which requires one should seek to economize by minimizing cost. By having the owner of MTC attend the conference rather than send agency personnel was an attempt by the Provider to minimize costs. It was far more economical to travel from Chicago to Boston than from Salt Lake City, Utah to Boston.

The Provider notes that while the Intermediary points out that MTC consults with other home health agencies, MTC also sent two other consultants to attend the seminar. For the Intermediary to preclude any allowance of this cost to the Provider would shift costs inappropriately away from the Medicare program.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the audit adjustment to disallow travel costs was made in accordance with the provisions of Medicare regulations 42 C.F.R. §§ 413.9 and 413.24 and HCFA Pub. 15-1 §§ 2102, 2103, 2105 and 2304.

It is the Intermediary's position that the invoice for $177 to pay for Mr. Plonsey's flight from his home in Florida to the MTC office in Illinois is not a Medicare reimbursable cost. The Provider has not supplied documentation to demonstrate that the cost is related to the operations of the facility. This does not meet the requirement of HCFA Pub. 15-1 §§ 2105.6 or 2102. According to these sections, travel costs incurred in connection with non-patient care are not allowable.

The Intermediary notes that the Provider submitted on its as-filed cost report the cost for Mr. Plonsey to attend the Texas Association of Home Care meeting ($566). The Provider has not supplied documentation, as required under 42 C.F.R. § 413.20, to support how this related to the Provider's patient care. The Provider is located in Utah.

The Intermediary observes that the Provider also submitted the cost for Mr. Plonsey to attend the NAHC convention in Boston ($773). Mr. Plonsey provides consulting services to other home health agencies in addition to his role with the Provider, and the information he gained at the NAHC meeting is utilized in his work for his other clients in addition to the Provider. It is not reasonable or prudent for the Provider to bear the cost of these conventions since other providers will realize the benefits as well. To include the entire cost on the Provider's cost report would not comply with 42 C.F.R. § 413.9. The cost of attending the Texas Association meeting should not be allowed because the targeted audience would be home health agencies in Texas.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, facts and parties' contentions, finds and concludes as follows.

Issue No.1 - Home Office Costs

The Board finds that this issue appears to be a home office cost allocation issue. The parties argue over whether the Provider can use the pooled allocation method to distribute costs to the Provider and to MTC because the chain organization created by MTC only had one provider. The Board finds that HCFA Pub. 15-2 §1000 permits the use of the pooled allocation method when there is only one provider. In fact, the Intermediary allowed this method for the Provider's 1998 and 1999 Medicare cost reports.

The Board finds, however, that there is nothing of consequence to support the Provider's claimed home office costs. The only evidence submitted was a summary schedule of costs which the Board finds did not tie into the cost report amounts. Its failure to

document costs, as alleged by the Intermediary,[9] results in the Provider's non-compliance with the recordkeeping requirements of 42 C.F.R. §§ 413.20 and 413.24. The Intermediary requested additional information[10] but received no response. The Board, therefore, concludes that the pooled allocation costs are inadequately supported and are disallowed. The Board does note that the Intermediary did allow MTC costs directly assigned to the Provider by MTC.

Issue No 2 - Auto Allowance

The Board concludes that the allowances given to the Provider's administrator and nursing administrator for the personal use of their autos were reasonable and, thus, are allowable. The Board notes that such costs were allowed by the Intermediary in the past. The Provider had mileage logs, and the Intermediary had reviewed them.

Issue No. 3 - Travel Costs

The Board finds Mr. Plonsey's travel costs of $177 from Florida to Illinois nonallowable. There is no documentation or argument by the Provider to support that the costs are allowable. Regarding the remaining travel cost claims (cost of Texas Association meeting and NAHC conference), the Board finds these costs reasonable. However, they should be included in pooled or shared costs of the chain organization. These costs should then be allocated to the Provider based on the pooled allocation method discussed in Issue No. 1 above.

DECISION AND ORDER:

Issue No. 1 - Home Office Costs

The home office costs claimed were not properly documented. The Intermediary's adjustment is affirmed.

Issue No. 2 - Auto Allowance

The auto allowance paid to the Provider's administrator and nursing administrator are allowable. The Intermediary's adjustments are reversed.

Issue No. 3 - Travel Costs

A portion of the travel costs ($177) are disallowed. The remaining travel costs are reasonable travel costs and should be treated as part of home office costs and allocated using the HOCS allocation method. The Intermediary's adjustments are reversed or modified in part.

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[9] See, Intermediary Position Paper, p.10.
[10] See, Intermediary Exhibit 13.

BOARD MEMBERS PARTICIPATING:

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

DATE: September 24, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman