PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D14

PROVIDER – Countryside Manor Health Care Center Anderson, Indiana	**DATE OF HEARING -** April 27, 2004
Provider No.: 15-5258	Cost Reporting Period Ended - December 31, 1997
vs.	
INTERMEDIARY – BlueCross BlueShield Association/ AdminaStar Federal - Indiana	**CASE NO.**: 00-0945

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ISSUES:

1. Whether the Intermediary's adjustment to disallow a portion of the owners' compensation was proper?

2. Whether the Intermediary's adjustment to disallow bad debts was proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Countryside Manor Health Care Center (Provider) is a 130 bed skilled nursing facility located in Anderson, Indiana. For the fiscal period ended 12/31/97, the Provider claimed owners' compensation and bad debts on its cost report. AdminaStar Federal (Intermediary) examined the cost report and disallowed substantial portions of the amounts claimed for both. The specific history for each issue is as follows:

Issue 1: Owners' Compensation

The Provider's ownership is divided among four individuals, each of whom maintains other business interests that are unrelated to the Provider's operations. For fiscal 1997, the Provider paid $122,400 to the four owners. Of that amount, the Provider offset $49,804 in excess compensation on its "as filed' cost report. The Provider calculated the excess compensation by

considering the size and location of the facility and the experience, education and duties of each of the owners. The Intermediary performed a desk audit of the 12/31/97 cost report and determined that the documentation was inadequate to substantiate that the four owners rendered direct or indirect patient care services. Consequently, the Intermediary eliminated all owners' compensation ($62,996) in excess of $200 per month paid to each of the owners for their attendance at board meetings, leaving $9,600 in allowable owners' compensation.

Issue 2: Bad Debts

The Provider also claimed $6,373 for bad debts on its cost report. During its desk review, the Intermediary requested documentation to support the amount claimed. The Provider submitted a one-page document that listed four names and the amount claimed for each. The Intermediary reviewed the list and rejected it because the Provider did not include the information to claim bad debts that is required by Provider Reimbursement Manual (PRM) 15-1, sections 304, 308, 310, and 314. Consequently, the Intermediary disallowed the total amount claimed.

PARTIES' CONTENTIONS:

Issue 1: Owners' Compensation

The Provider contends that the owners' job responsibilities include managerial, administrative and professional services that are necessary for the operation of the facility. The Provider further contends that the owners' responsibilities are required for the supervision of the facility and include the acceptance of legal liabilities and negotiation authorities. The Provider also argues that the owners' activities are comparable to the services offered by a home office and should be viewed in relation to reasonable costs incurred by chain organizations.

The Intermediary contends that the Provider's Owner's Compensation Survey Questionnaire (Schedule IV of HCFA Form 339) indicated that the owners attended quarterly board meetings, but otherwise devoted little or no time to the Provider's operations. Further, the Provider employs one full-time Administrator, one full-time Director of Nursing and one full-time Assistant Director of Nursing. Consequently, none of the owners renders services to the facility as its manager or administrator. Further, the Provider offered no documentation to support that the owners are involved in the operation or management of the facility's delivery of patient services.

Issue 2: Bad Debts

The Provider contends that it substantiated the amounts reported as allowable bad debts derived from unpaid coinsurance in accordance with the criteria for allowable bad debts set forth in PRM 15-1, section 308. The Provider also asserts that it demonstrated that it made reasonable collection efforts as required by PRM 15-1, section 310. The Provider further argues that it maintained all necessary supporting information to justify the bad debt reported on the cost report.

The Intermediary contends that the Provider supplied a one-page document that listed four names without any of the information required by PRM 15-1, section 308 (and outlined in HCFA Form 339 at Section L). The Intermediary also argues that the Provider offered nothing to evidence that collection attempts had ever been made and failed to produce any documentation beyond the single-page list offered pursuant to the Intermediary's request.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

During the proceedings the Board asked several questions, the answers to which required additional information beyond that available within the record or at the immediate disposal of the Provider. Consequently, the Provider requested that the Board allow it to submit additional information in response to the Board's questions and in support of its position. The Board carefully considered the facts and circumstances of the Provider's case. Our considerations indicated that the matters questioned were all in issue well in advance of the hearing and that the Provider had ample opportunity to present any evidence in support of its position. No testimony was offered by the individuals with personal knowledge of the facts in dispute. The Board believes that the questions asked at the hearing should have been properly supported by the testimony and evidence available at the proceeding. To allow additional information after the hearing was concluded would, in effect, afford a second appeal opportunity for the Provider's position. Consequently, the Board did not accept or entertain any additional submissions for the Provider's appeal. Rather, the Board limited its deliberations to the information that had been timely submitted by both parties prior to the hearing and the testimony offered into evidence during the hearing.

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at the hearing, finds and concludes the following:

Issue 1: Owners' Compensation

The dispute over the amounts claimed for owners' compensation centers on the nature/need of the services provided by the owners. The controlling regulation for owners' compensation appears at 42 C.F.R. §413.102(a), which recognizes compensation of owners as an allowable expense provided the services are actually performed in a necessary function. In addition, 42 C.F.R. §413.102(b)(3)(1) requires that, for a service to be necessary, the institution would have had to employ another individual to perform it had the owner not done so.

In this case, the Provider argued that the owners provided services that were necessary for the operation and supervision of the facility. However, the Provider was unable to supply auditable documentation in support of its contention. Despite the opportunity to offer testimony or other evidence, the Provider limited its evidence to an un-sworn listing of the owners' general duties. As submitted, the listing provides no foundation upon which the Board can conclude that the owners actually provided the services that are listed or that the owners were involved, directly or indirectly, with patient care at the facility.

It is undisputed that the owners had several other business enterprises to which they also devoted time and that the Provider employed full-time staff to manage and direct the day-to-day operations and patient service delivery functions of the facility. Absent documentation to the contrary, the Board must conclude that the staff discharged its managerial and patient service responsibilities and, in so doing, obviated the need for significant involvement by the owners in the facility's daily operations. Accordingly, the Board must also conclude that the Intermediary properly adjusted the amounts claimed by the Provider for the owners' involvement in the operation of the facility.

Issue 2: Bad Debts

The dispute over bad debts centers on the adequacy of the documentation offered in support of the amounts claimed. The controlling regulations for Medicare bad debts are 42 C.F.R. §413.24, which requires that providers submit cost data that is adequate to support their claims, and 42 C.F.R. §413.80, which identifies the type of information that is required to support a claim for bad debts. In addition, PRM 15-1, section 300 provides additional instructions for providers to claim bad debts. The collective requirements of the regulations and the PRM instructions are reflected in CMS's Cost Report Questionnaire at Section L, which includes a template for a bad debt listing that providers may use when claiming Medicare bad debts.

The Provider contended that it had supplied documentation that was consistent with the criteria for allowable bad debts set forth in PRM 15-1, sections 308 and 310. However, the Board's examination indicated that the Provider's support consisted of a single, un-sworn document that listed four names and an amount for each name. A comparison of the requirements of Section L of the Cost Report Questionnaire to the information submitted by the Provider indicates that the Provider's information addresses only two of the ten elements required by the questionnaire. Consequently, the Board considers the information offered by the Provider inadequate to support a claim for bad debts and concludes that the Intermediary properly disallowed the bad debts claimed by the Provider.

DECISION AND ORDER:

Issue 1: Owners' Compensation

The Intermediary's adjustment is affirmed.

Issue 2: Bad Debts

The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.

Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: December 17, 2004

Suzanne Cochran, Esquire
Chairperson