PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D33

PROVIDER -
California Nurses Home Health Services
Los Angeles, California

Provider No.: 05-8034

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC--CA

DATE OF HEARING -
February 16, 2005

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 03-0055

INDEX

ISSUE:

Was the Intermediary's adjustment to start-up costs proper?

STATEMENT OF THE CASE AND STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due 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 & 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.

California Nurses Home Health Services, Inc. (Provider) is a for-profit, freestanding, home health agency (HHA) located in Los Angeles, California. During its Medicare cost reporting period ended June 30, 2000, the Provider claimed start-up costs of $126,522. This amount represented the costs the Provider accumulated in developing its ability to furnish patient care up to July 17, 1998, which is the date it became certified to participate in the Medicare program. United Government Services (Intermediary) audited the Provider's cost report and reduced the claimed start-up costs to $21,835; this is the amount of costs the Provider accumulated in developing its ability to furnish patient care up to March 31, 1998, which is the date the Provider saw its first patient.

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $90,000.

The Provider was represented by Rocky Gentner of Gentner and Company. The Intermediary was represented by George R. Garcia, United Government Services.

PARTIES' CONTENTIONS:

The Intermediary contends that section 2132 of the Provider Reimbursement Manual, Part I, (HCFA Pub.15-1) defines start-up costs as those costs incurred by a provider in developing its ability to furnish patient care up to the date it sees its first patient. The Intermediary refers to a letter written by the CMS San Francisco Regional Office on April 16, 1998. It explains that HCFA Pub. 15-1 §2132, Start-up Costs, applies to all provider types, including HHAs, and that start-up costs accumulate up to the date a provider's operations begin, which is the date an HHA renders its first patient care visit.[1]

The Provider contends that the manner in which HCFA Pub. 15-1 §2132 is written shows that it applies to hospitals and not to HHAs. The manual states that start-up costs "are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment. . . .". HCFA Pub. 15-1 §2132.2. The Provider asserts that the manual's nomenclature applies to hospitals, since HHAs rarely construct, purchase or expand their facilities; nor do they admit patients.

The Provider also contends that HHAs should be permitted to accumulate start-up costs up to the date they are certified as a Medicare provider because the certification process is different for HHAs than it is for hospitals. Hospitals can become certified when their physical space is ready, which means they can become certified and subsequently reimbursed when services are furnished to their very first patient. In contrast, HHAs must perform 10 patient care visits before they can become certified. Since practically all HHA patients are covered by either Medicare or Medicaid, and since these programs will not pay for home care visits until an HHA is certified, the costs of these 10 visits is not reimbursed unless they are recognized as start-up costs.

In addition, the Provider contends that even if Medicare policy allows start-up costs to accumulate only up to the date an HHA performs its first patient care visit, it is arguable that a "visit" is not performed until an HHA is certified. The Provider refers to 42 C.F.R. §409.48, which defines a visit as "an episode of personal contact with the beneficiary. . . for the purpose of providing a covered service." (emphasis added). The Provider asserts that since the purpose of an HHA initially seeing patients is to develop its ability to furnish patient care services and not for the purpose of providing a covered service, visits are not being performed until after certification.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and program guidelines, parties' contentions and evidence presented, finds and concludes that the Intermediary properly adjusted the Provider's start-up costs. The Intermediary limited start-up costs to those costs accumulated by the Provider up to the date it saw its first patient, as opposed to the date the Provider became certified to participate in the Medicare program.

[1] Intermediary's Supplemental Position Paper at 6. Exhibit I-4.

No factual issues are in dispute. The parties' arguments center on whether or not the provisions of HCFA Pub. 15-1 §2132 apply to HHAs. These manual instructions are the only program guideline that directly address the "time" that the accumulation of start-up costs ends.

The Provider argues that HCFA Pub. 15-1 §2132.2 "refers to the building of acute care hospitals, and does not apply to home health agencies." The Board disagrees and notes that the manual does not mention any specific type of provider (hospital, skilled nursing facility, or HHA), and that the accumulation and amortization of start-up costs would logically apply to all providers reimbursed on a reasonable cost basis. Therefore, the Board finds that the manual's general instruction at HCFA Pub. 15-1 §2132.1 establishes the time that the accumulation of start-up costs ends. These instructions explain that start-up costs are incurred during the time a provider is developing its ability to furnish patient care services and, for an HHA, would end when it performs its first patient care visit.

The Board also disagrees with the Provider's argument that start-up costs should accumulate up to the date an HHA is certified, because neither Medicare nor Medicaid will reimburse any of its patient care visits until that time. However, this is a billing matter that only applies to the two governmental programs and does not affect third party or private pay patients. Similarly, the Board disagrees with the Provider's argument that a visit is not actually performed unless it is for the purpose of furnishing a "covered service," which equates to an HHA having obtained Medicare certification. The Board notes that this is an argument based solely upon program terminology which is a billing matter that is not dispositive of the start-up cost issue.

The Board concludes that the manual provision establishing the termination date for start-up costs as the date the first patient is treated is applicable to HHAs, is not inconsistent with the statutory provisions of 42 U.S.C. §1395x(v)(1)(A), Reasonable Cost, and is, therefore, controlling.

DECISION AND ORDER:

The Intermediary properly adjusted the Provider's start-up costs to those costs accumulated up to the date the Provider saw its first patient. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: April 11, 2005

Suzanne Cochran, Esq.
Chairman