PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D53

PROVIDER –
DePaul Health Center
Bridgeton, Missouri

Provider No.: 26-0104

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
March 4, 2005

Cost Reporting Period Ended -
June 30, 1993

CASE NO.: 96-0480

INDEX

ISSUE:

Whether the Intermediary's adjustment that disallowed the consolidation of all of the Provider's therapy services into a single cost center was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper 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 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.

The Medicare regulations and CMS' implementing instructions set the standards under which costs may be accumulated and reported for program reimbursement purposes. Specifically, the regulations at 42 C.F.R. §413.20 require the use of accounting practices that are widely accepted in the healthcare field. Further, CMS' Provider Reimbursement Manuals (PRM) 15-1 and 15-2 provide standardized definitions and instructions for the use of cost centers in the proper accumulation of costs and the completion of the cost report. The issue in this appeal involves the use of a single, consolidated cost center to accumulate and report the cost for all therapy services.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

DePaul Health Center (Provider) is a Medicare-certified acute care hospital located in Bridgeton, Missouri. For the cost reporting period ended June 30, 1993, the Provider reported all therapy services under one cost center entitled "Therapy Services." Mutual of Omaha (Intermediary) reviewed the cost center and found that it included services that would normally be reported on the Medicare cost report separately in the physical therapy, speech therapy and occupational therapy cost centers. The Intermediary considered the use of a single cost center inconsistent

with Medicare reimbursement principles presented at PRM 15-1 § 2302.8 and adjusted the Provider's cost report accordingly. The Provider appealed the adjustment. There is no dispute over the controlling Medicare regulations or instructions. The sole issue in this appeal is the propriety of reporting all therapy services in a single cost center.

PARTIES' CONTENTIONS:

The Provider contends that the Therapy Services cost center reflects its service-delivery philosophy that combines services to provide a continuum of care from pre-admission to post-discharge and allows therapists to co-treat a single patient. The organizational structure of the Therapy Services cost center facilitates the treatment of therapy patients in an environment that encourages interaction, cooperation, and collaboration among all the therapy disciplines for better clinical outcomes. The Provider also contends that the use of the combined center, for cost-reporting purposes, is a long standing practice that dates back to 1978. The Provider argues that the practice is used by other hospitals in the area and was not questioned by prior intermediaries.

The Provider further contends that the practice is consistent with PRM 15-1 §2302.8. This section requires that a cost center have ". . . a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned." The Provider argues that the Therapy Services center's clinical purpose is, in fact, its common functional purpose which is to treat its patient through a high quality, cohesive, integrated, multidisciplinary therapy team, at a reasonable cost.[1]

The Provider also disputes the Intermediary's assertion that the Therapy Services cost center shifts costs in violation of 42 C.F.R. §413.5(a). The Provider argues that an analysis of the Therapy Services center demonstrates that it provides a reasonable and consistent relationship of cost to charges and that Medicare utilization among therapies is consistent. Consequently, the Therapy Services center offers no incorrect payment potential.

The Intermediary asserts that the Therapy Services cost center is inconsistent with the regulation addressing the proper determination of costs at 42 C.F.R. §413.20(a) and with the cost reporting instructions at PRM 15-2 §3610. The regulation requires that providers use standardized definitions as well as accounting, statistics and reporting practices that are widely accepted in the hospital field. The PRM section requires the use of data available from the provider's basic accounts as they are usually maintained and does not allow for any changes to standard (i.e., preprinted) HCFA/CMS cost report line numbers and cost center descriptions. The Intermediary argues that the Therapy Services cost center includes services that would normally be separately reported on the Medicare cost report under the physical therapy, speech therapy and occupational therapy cost centers. Although the Provider maintained the necessary data to report the various therapies in separate cost centers, it elected to report the costs in the single Therapy Services cost center.

[1] See Provider's Post-Hearing Brief. Exhibit P-2.

The Intermediary also contends that the Therapy Services cost center violates the prohibition against cost shifting at 42 C.F.R. §413.5(a). The Intermediary argues that cost shifting will occur with the aggregation of services that have low cost to charge ratios and high Medicare utilization rates with services that have higher cost to charge ratios and lower Medicare utilization rates. The courts have agreed that the establishment of separate, distinct cost centers rather than combining all services into one cost center was more likely to eliminate cross subsidization.[2] The Intermediary further argues that the Board has consistently held that combining cost centers is not an accurate or more sophisticated method of allocation and would shift costs.[3]

The Intermediary argues further that, PRM 15-1 §2313.1 allows the provider to elect to use a single, unique center only where a written request was submitted to the Intermediary prior to the end of the reporting period and the Intermediary approved the request. The Provider never made the request and cannot unilaterally adopt the use of the single cost center.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions, and the evidence, finds and concludes as follows:

The issue presented for the Board's consideration is the propriety of consolidating all of the Provider's therapy services in a single cost center.

The regulation at 42 C.F.R.§ 413.20(a) requires that the Medicare settlement process use "[s]tandardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields . . . " Further, the section anticipates that the method of determining costs payable under the Medicare program "involves making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries." CMS' cost reporting instructions at PRM 15-2 Section 3610 mirrors the regulation and states: "In accordance with 42 C.F.R. §413.20, the methods of determining costs payable under title XVIII involve using data from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services." Accordingly, CMS designed its cost reporting forms based upon the hospital industry's accounting and reporting practices so that a provider may easily report costs from its accounting books and records and perform any necessary reclassifications and adjustments to its accounts for Medicare reporting purposes. These forms require physical, occupational and speech therapy services to be reported in separate cost centers and Section 3610 states: "Standard (i.e., preprinted) HCFA line numbers and cost center descriptions cannot be changed."

CMS provides its definition of a cost center at PRM 15-1 Section 2302.8:

> An organizational unit, generally a department or its subunit, having a common

[2] University Hospital Authority v. Shalala; U.S. District Court for the Western District of Oklahoma, No.CIV-93-4-D, May 24, 1994.
[3] PRRB Decision 77-D34,:May 12, 1977.

> functional purpose for which direct and indirect costs are accumulated, allocated and apportioned. In addition, those natural expense classifications (e. g., depreciation) and nonallowable cost centers (e.g., research) specifically required by the instructions to be shown on the cost report fall under this definition . . .

The Board's examination of the record and the testimony offered at the hearing indicated that the Provider did, in fact, maintain accounting records in a manner consistent with industry-wide hospital accounting and reporting practices. The Provider furnished various therapy services as separate functions and maintained the necessary data to track the respective costs and revenues of each separately. Despite the availability of this data, the Provider elected to report its therapy costs for Medicare reporting purposes in a single cost center. The Board considers this election inconsistent with both Medicare regulations and CMS' guidance. The Board finds that the application of accepted hospital reporting practices and the natural expense classifications articulated in PRM 15-1 Section 2302.8 require the separation of therapies into distinct cost centers.

Further, the record indicated that the use of a single therapy cost center produced a wide variance in the cost center's cost to charge ratio as well as its Medicare utilization. Where such variations existed, the Board has traditionally held that the use of a single cost center was not a more accurate allocation of Medicare cost, nor a more sophisticated method of allocating costs.

The Board recognizes that PRM 15-1 Section 2313.1 allows a provider to elect to use its unique cost center(s) in lieu of the recommended cost centers on the cost reporting forms. However, that instruction requires the provider to demonstrate that the unique/single center will produce a more accurate cost finding. In addition, approval from the Intermediary for the use of the cost center and the proposed basis of allocation must be evidenced in writing. In this case, the Provider did not furnish any evidence to demonstrate that the Intermediary's approval was requested and/or received for the use of the single cost center nor that its use would result in a more accurate cost allocation. Absent such evidence the Board concludes that the Section 2313.1 election is not available to the Provider.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the consolidation of all of the Provider's therapy services into a single cost center was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: September 15, 2006

Suzanne Cochran, Esquire
Chairperson