PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D74

PROVIDER -
Logos Healthcare Rehabilitation of South Carolina, Inc.
West Columbia, SC

Provider No.: 42-6548

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Palmetto Government Benefits Administrators

DATE OF HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 00-3354

INDEX

ISSUES: [1]

1. Was the Intermediary's adjustment to Medicare bad debts proper?
2-5. Were the Intermediary's adjustments to salaries - administrative, physical therapy, occupational therapy, and speech therapy - proper?
6. Was the Intermediary's adjustment to travel expense - administrative - proper?
7. Was the Intermediary's adjustment to telephone expense proper?
8. Was the Intermediary's adjustment to consultant expense proper?
9. Was the Intermediary's adjustment to rent expense proper?
10-12. Was the Intermediary's adjustment to other charges – physical, speech and occupational therapy - proper? (Provider's Issue 10)

MEDICARE 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 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. §1395h, 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 portion 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:

Logos Healthcare Rehabilitation of South Carolina, Incorporated (the Provider) is a privately owned, for-profit, outpatient rehabilitation facility located in West Columbia, South Carolina. The Provider was one of three Medicare-certified facilities in the PTK Management Incorporated (PTK) chain of health care facilities. The Provider furnished

[1] The Provider and Intermediary issue numbers are the same in this case except for issues 10 through 12. For simplicity, this decision uses the Intermediary's issue numbers and notes the different Provider issue numbers in parenthesis.

outpatient physical, speech, and occupational therapy to Medicare patients in various nursing homes. The Provider claimed costs for its facility's services on its fiscal year ended December 31, 1996 cost report and also included home office costs allocated from PTK.

The Provider terminated from the Medicare program on April 30, 1999. The Provider's fiscal intermediary at the time of its termination was Blue Cross Blue Shield of North Carolina.[2] The Intermediary entered into an inter-plan agreement with First Coast Service Options, Incorporated (First Coast) to perform the outstanding audits on all Logos facilities. First Coast made the audit adjustments at issue in this case in a Notice of Program Reimbursement (NPR) issued on June 27, 2000. The Provider timely appealed the adjustments to the Provider Reimbursement Review Board (Board) and met the jurisdictional requirements of 42 C.F.R. §§405.1831-405.1841.

The Board held a hearing for this case on November 7, 2001. Because of concerns raised at the hearing, the Board suspended the hearing and agreed to hear this case on the written record. See, Tr. at 11. Because so many of the Intermediary's adjustments were due to lack of documentation and the Provider contended that a full review of its documentation had not occurred, the Board asked that additional audit work be performed and allowed the Provider to submit additional documentation. At the Board's request, the Intermediary reviewed the additional documentation and on January 30, 2003, submitted a report and made post-audit adjustments. See, Exhibit I-4.

In order to facilitate consideration of the case on the record, the Board asked the Intermediary to submit a supplemental position paper that addressed any costs disallowed after the reaudit and state: 1) why the initial audit adjustment was made; 2) what additional documentation the Provider submitted; and 3) why that documentation was not sufficient to reverse the adjustment.[3] After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a brief in response to the Intermediary's revised positions and to submit to the Board documentation necessary to support its position. The Intermediary submitted its supplemental position paper on March 30, 2005. The Provider did not submit anything further. The record hearing was held on June 10, 2005.

The Provider was represented by Thomas William Baker, Esquire, of Troutman Sanders LLP. The Intermediary was represented by Eileen Bradley, Esquire, and Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue 1. Was the Intermediary's adjustment to Medicare bad debts proper?

FACTS:

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[2] Currently, Cahaba Safeguard Administrators, LLC is the Program Safeguard Contractor and Palmetto Government Benefits Administrator is the Intermediary. All three entities will be referred to as the Intermediary.

[3] See, Board letter dated January 28, 2005.

The Provider claimed Medicare bad debts which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny Medicare bad debts because the documentation was inadequate.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of Medicare remittance advices and account statements, the Intermediary did not allow any additional reimbursement because the Provider failed to submit any patient history reports that are necessary for a comprehensive record of payments on each account related to deductibles and coinsurance. See, Intermediary Supplemental Position Paper at 8.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to determine whether the Provider had sufficient documentation to support its bad debt claims. The Board finds that without proper documentation, the Provider's claim for bad debts is not supported, and the Intermediary's adjustment was proper.

Issues 2-5. Were the Intermediary's adjustments to salaries – administrative, physical therapy, speech therapy and occupational therapy - proper?

FACTS:

The Provider claimed salaries – physical therapy, speech therapy, occupational therapy and administrative and general which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional salary where adequate documentation was presented. See, Intermediary's Supplemental Position Paper at 8-11.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of

W-2 forms, payroll register reports and quarterly tax returns, the Intermediary allowed documented salaries and proposed to adjust all salary expenses together. See, Intermediary's Supplemental Position Paper at 8-11 and Exhibit I-6, pages 2-18.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Intermediary reviewed additional documentation submitted by the Provider and proposed a single adjustment to allow additional costs to administrative and general salaries. The Intermediary initially adjusted salaries for each affected cost center, and the Board believes that in reversing these adjustments the Intermediary should do so for each affected cost center rather than just a single adjustment to the administrative and general cost center. The Board observes that this can be done by determining the percentage of disallowance for each specific cost center. The Board remands the matter to the Intermediary to recalculate the proposed adjustments by specific cost center.

Issue 6. Was the Intermediary's adjustment to travel expense – administrative - proper?

FACTS:

The Provider claimed travel expense – administrative – which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional travel expense. See, Intermediary's Supplemental Position Paper at 10-11.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation which consisted of invoices and expense reports, the Intermediary allowed additional travel expenses where documented costs could be traced to the general ledger. See, Intermediary's Supplemental Position Paper Exhibit I-6 at pages 19-20.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Although the documentation relied on by the Intermediary to support the revision to its adjustments was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 7. Was the Intermediary's adjustment to telephone expense proper?

FACTS:

The Provider claimed telephone expense which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional telephone expense where documentation was adequate. See, Intermediary's Supplemental Position Paper at 11.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices, the Intermediary allowed additional telephone expense where the documentation could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at pages 21-22.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 8. Was the Intermediary's adjustment to consultant expense proper?

FACTS:

The Provider claimed consultant expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny these costs because the documentation did not pertain to the fiscal year at issue. See, Intermediary's Supplemental Position Paper at 11-12.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices, the Intermediary found that the invoices did not pertain to the fiscal year at issue. See, Intermediary's Supplemental Position Paper, Exhibit I-7 at pages 1-12. The Intermediary did not propose any change to its adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Based on the documentation relied on by the Intermediary to support its decision not to revise its adjustment, the Board agrees that these invoices do not pertain to the fiscal year at issue. The Intermediary's adjustment was proper.

Issue 9. Was the Intermediary's adjustment to rent expense proper?

FACTS:

The Provider claimed rent expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny these costs because the documentation was inadequate. See, Intermediary's Supplemental Position Paper at 12.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices and checks, the Intermediary proposed no adjustment because no rental agreements or contracts were provided. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 30.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Based on the documentation relied on by the Intermediary to support its decision not to revise its adjustment, the Board finds the documentation submitted was inadequate to support the claimed costs. The Board agrees that the Intermediary's adjustment was proper.

Issues 10-12. Were the Intermediary's adjustments to other charges - physical, speech and occupational therapy – proper?

FACTS:

The Intermediary made an adjustment to reconcile Medicare therapy charges per the as-filed cost report to the Provider Statistical and Reimbursement Report (PS&R). Since total therapy charges come from the Provider's records and are not impacted by this reconciliation, decreases in Medicare charges precipitate an increase in "other charges."

Other charges usually represent denied claims for therapy services. After its review of additional documentation furnished by the Provider, the Intermediary did not revise its original adjustment due to lack of supporting documentation. See, Intermediary's Supplemental Position Paper at 13-14.

PARTIES' CONTENTIONS:

The Provider disagrees with the Intermediary's increase of the Provider's non-Medicare charges. The Provider claims that non-Medicare charges were not listed on the PS&R and that it maintained financial logs to record all charges. The Provider asserts that these logs were available to the Intermediary during the review and that the Intermediary did not make a written request for this information. The Provider contends that the adjustment was made without any basis and should be reversed.

The Intermediary made an adjustment to reconcile the Medicare charges and other charges to agree with the PS&R and to reconcile to total charges. The Intermediary states that the Provider submitted in-house Medicare patient logs to be used instead of the PS&R but that it did not submit supporting documentation, such as Medicare remittance advices, to prove its log was more accurate than the PS&R. The Intermediary did not propose any change to its adjustment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Provider did not submit sufficient documentation to support its claim. Therefore, the Board finds that the Intermediary's adjustment to reconcile the Medicare charges and other charges to agree with the PS&R was proper.

DECISIONS AND ORDERS:

Issue 1. Was the Intermediary's adjustment to Medicare bad debts proper?

The Board finds that the Provider did not provide sufficient documentation to support its claim for Medicare bad debts. The Intermediary's adjustment is affirmed.

Issues 2-5. Were the Intermediary's adjustments to salaries – administrative, physical therapy, occupational therapy and speech therapy – proper?

The Board finds that the Intermediary's proposal to add all of the additional salary costs only to the administrative and general cost center is improper. The Board remands the matter to the Intermediary to revise the proposed adjustments by cost center.

Issue 6. Was the Intermediary's adjustment to travel expense – administrative – proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional travel expenses.

Issue 7. Was the Intermediary's adjustment to telephone expense proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional telephone expenses.

Issue 8. Was the Intermediary's adjustment to consultant expense proper?

The Board finds that the Provider did not provide documentation to support its consultant expense. The Intermediary's adjustment is affirmed.

Issue 9. Was the Intermediary's adjustment to rent expense proper?

The Board finds that the Provider did not provide sufficient documentation to support its rent expense. The Intermediary's adjustment is affirmed.

Issues 10-12. Was the Intermediary's adjustment to other charges – physical, speech and occupational therapy - proper? (Provider's Issue 10)

The Board finds that the Provider did not furnish documentation to support its claim that the Intermediary's adjustment to physical, speech and occupational therapy – other charges was incorrect. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: September 21, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman