PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D76

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, 1997

CASE NO.: 00-3355

INDEX

ISSUES: [1]

1. Was the Intermediary's adjustment to salaries proper?
2. Was the Intermediary's adjustment to contract labor proper?
3. Was the Intermediary's adjustment to advertising expense proper?
4. Was the Intermediary's adjustment to utilities expense proper?
5. Was the Intermediary's adjustment to travel expense proper?
6. Was the Intermediary's adjustment to rent expense proper?
7. Was the Intermediary's adjustment to professional fees proper?
8. Was the Intermediary's adjustment to office expense proper?
9. Was the Intermediary's adjustment to dues and subscriptions proper?
10. Was the Intermediary's adjustment to physical therapy – total charges proper?
11. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 12)
12. Was the Provider's request for costs incurred in settling the cost reports after termination from the Medicare program proper? (Provider Issue 11)

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.

[1] The Provider and Intermediary issue numbers are the same in this case except for issues 11 and 12. For simplicity, this decision uses the Intermediary's issue numbers and notes the different Provider issue numbers in parenthesis.

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 healthcare facilities. The Provider furnished 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, 1997 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 its report and made post-audit adjustments. See, Exhibit I-4.

In order to facilitate consideration of the case on the record, the Board asked[3] 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. After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a response 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.

---

[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 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 the Blue Cross Blue Shield Association.

1. Was the Intermediary's adjustment to salaries proper?

FACTS:

The Provider claimed certain salaries which the Intermediary disallowed for lack of documentation. After reviewing additional documentation submitted by the Provider, the Intermediary continued to deny the costs 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 a year-to-date earnings report itemized by employee, the Intermediary continued to disallow the cost because the earnings report did not tie to the general ledger or income statement. 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 claim for salaries. The Board finds that without proper documentation, the Provider's claim for salaries is not supported, and the Intermediary's adjustment was proper.

2. Was the Intermediary's adjustment to contract labor proper?

FACTS:

The Provider claimed contract labor which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional costs where documentation was adequate. See, Intermediary's Supplemental Position Paper at 8.

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 copies of corresponding checks showing that the Provider paid the invoices, the Intermediary allowed additional documented costs that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper Exhibit I-6 at 14-16.

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 documentation relied on by the Provider to support its claimed costs was not placed in the record by the Provider. Absent any documentation in the record, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 3. Was the Intermediary's adjustment to advertising expense proper?

FACTS:

The Provider claimed advertising expense which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary did not allow any additional advertising expense because the documentation was inadequate. See, Intermediary's Supplemental Position Paper at 9.

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. The Provider states that it had two advertising accounts – one for advertising for employees and another for general advertising. The Provider states that it did not claim advertising costs for general advertising but that advertising for employees is an allowable expense under CMS Pub. 15-1 §2136 and should be permitted.

After reviewing the Provider's submission of additional documentation consisting of invoices and copies of corresponding checks showing that the Provider paid the invoice, the Intermediary continued to disallow these cost because the Provider's home office arbitrarily split the cost between the providers in the organization without explaining the basis for the allocation of the cost. See, Intermediary's Supplemental Position Paper Exhibit I-6 at pages 17-20.

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:

The Board finds that the documentation relied on by the Provider to support its claimed costs was not placed in the record. The Board notes that the Provider was part of a larger organization that included a non-Medicare facility, therefore, the allocation of costs among the entities needs to be documented to ensure there is no cost shifting or non-allowable costs apportioned to Medicare providers. Absent such documentation in the record, the Board finds that the Intermediary's adjustment was proper.

Issue 4. Was the Intermediary's adjustment to utilities expense proper?

FACTS:

The Provider claimed utilities expense which the Intermediary disallowed due to lack of documentation. After reviewing the additional documentation supplied by the Provider, the Intermediary allowed additional documented costs for telephone expense. See, Intermediary's Supplemental Position Paper at 10.

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 corresponding checks paid by the Provider, the Intermediary allowed additional costs for utilities expense where the documentation could be traced to the general ledger. The Intermediary continued to disallow utility costs that had been arbitrary assigned to the Provider without support for the split among all entities in the chain. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at pages 21-25.

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

Issue 5. Was the Intermediary's adjustment to travel expense proper?

FACTS:

The Provider claimed travel expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional documented costs for travel expense. See, Intermediary's Supplemental Position Paper at 10.

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 corresponding checks paid by the Provider, the Intermediary allowed additional travel expense for which the documented costs could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-4.

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 documentation relied on by the Provider to support its claimed costs was not placed in the record. Absent such documentation in the record, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 6. 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 allowed additional rent expense. 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 and checks paid by the Provider, the Intermediary allowed additional rent expense where documented costs could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 26-29.

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 documentation relied on by the Provider to support its claimed costs was not placed in the record. Absent such documentation in the record, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 7. Was the Intermediary's adjustment to professional fees proper?

FACTS:

The Provider claimed professional fees which the Intermediary adjusted due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional professional fees. 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 submission of additional documentation in the form of invoices and checks paid by the Provider, the Intermediary allowed additional professional fees where documented costs could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 30-32.

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 documentation relied on by the Provider to support all its claimed costs was not placed in the record. Absent such documentation in the record, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

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

FACTS:

The Provider claimed office expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional costs where the documentation was adequate. 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 paid by the Provider, the Intermediary allowed additional office expense where documented costs could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 33-39.

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 upon the Intermediary's analysis of additional documentation, it proposed to revise the original adjustment. The Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 9. Was the Intermediary's adjustment to dues and subscriptions proper?

FACTS:

The Provider claimed dues and subscription expenses which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation submitted by the Provider, the Intermediary allowed additional dues and subscription expenses. See, Intermediary's Supplemental Position Paper at 13.

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 paid by the Provider, the Intermediary allowed additional dues and subscription expenses where adequate documented was submitted. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 40-42.

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 upon the Intermediary's analysis of additional documentation, it proposed to revise the original adjustment. The Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 10. Was the Intermediary's adjustment to physical therapy – total charges proper?

FACTS:

The Intermediary made an adjustment to reconcile total physical therapy charges per the as-filed cost report to the Provider's working trial balance. The charges reconciled without exception. The Intermediary did not change its adjustment because the Provider did not submit any additional documentation for this issue. See, Intermediary's Supplemental Position Paper at 14.

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's adjustment reconciling total physical therapy charges to the Provider's records was correct and is affirmed.

Issue 11. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 12)

FACTS:

The Provider claimed home office costs. The Intermediary adjusted the Provider's cost report to agree with the audited home office cost statement, and after reviewing additional documentation supplied by the Provider, the Intermediary allowed some additional home office costs.

PARTIES' CONTENTIONS:

The Provider contends that home office administrative services were provided by PTK Management, Inc., and the costs for those services were allocated to the individual entities that utilized PTK's services. The Provider maintains that these costs had been allowed in 1992 and later years, and therefore should be allowed.

After reviewing the Provider's submission of additional information to support its revisions to allowable home office costs, the Intermediary allowed some additional costs. See, Exhibits I-4.

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:

Neither the Provider's nor the Intermediary's position paper adequately addresses this issue or presents sufficient documentation and/or explanation to allow the Board to decide the issue. The Board is aware that the home office is not a provider and that costs incurred by the home office are allocated to the entities served by the home office. The problem with these costs, in addition to the lack of adequate documentation, is the lack of support for the allocation of home office costs to the Provider. This problem has also been noted in other issues (Issue 3). The Provider claims that its cost allocation was allowed in fiscal 1992. The Board finds, however, that whatever the circumstances were in fiscal year 1992, the Provider is not relieved of its obligation to support its allocation in the current fiscal year. Without further explanation and documentation from the Provider, the Board finds the Intermediary's proposed revision of home office cost is proper.

Issue 12. Was the Provider's request for costs incurred in settling the cost report after termination from the Medicare program proper? (Provider Issue 11)

FACTS:

The Provider wishes to claim additional costs incurred by the home office in settling the 1993 through 1997 cost reports with the Intermediary after termination from the Medicare program in the cost report under appeal. See Intermediary's Supplemental Brief at 14 and Provider's Exhibit P-11.

PARTIES' CONTENTIONS:

The Provider requested that the costs related to settling its 1993 through 1997 cost reports with the Intermediary be included in its 1997 cost report. The Provider notes that CMS Pub. 15-1 §2176 states that direct administrative costs, including legal and hearing fees incurred in terminating from the Medicare program, are allowable in settling of cost reports with the Intermediary.

The Intermediary notes that the Provider terminated from the Medicare program on April 30, 1999, and that any allowable termination costs should be included in its 1999 terminating cost report. The Intermediary states that it cannot allow these costs in a cost report for a period two years sooner because the regulation at 42 C.F.R. §413.9 only allows actual costs incurred during the cost report period, not future costs.

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:

Termination costs are allowable in a terminating cost report. However, since the Provider terminated from the Medicare program in 1999, it should claim those costs in its 1999 terminating cost report. The Board finds no basis to add these costs to the fiscal year at issue.

DECISIONS AND ORDERS:

Issue 1. Was the Intermediary's adjustment to salaries proper?

The Board finds that the Provider failed to provide adequate documentation to support its claim. The Intermediary's adjustment is affirmed.

Issue 2. Was the Intermediary's adjustment to contract labor 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 costs.

Issue 3. Was the Intermediary's adjustment to advertising expense proper?

The Board finds that the Provider failed to provide adequate documentation to support its claim. The Intermediary's adjustment is affirmed.

Issue 4. Was the Intermediary's adjustment to utilities 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 costs.

Issue 5. Was the Intermediary's adjustment to travel 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 costs.

Issue 6. Was the Intermediary's adjustment to rent 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 costs.

Issue 7. Was the Intermediary's adjustment to professional fees 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 costs.

Issue 8. Was the Intermediary's adjustment to office 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 costs.

Issue 9. Was the Intermediary's adjustment to dues and subscriptions 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 costs.

Issue 10. Was the Intermediary's adjustment to physical therapy – total charges proper?

The Board finds that the Provider failed to provide any documentation regarding the inaccuracy of the Intermediary's adjustment. The Intermediary's adjustment is affirmed.

Issue 11. Was the Intermediary's adjustment to home office costs proper? (Provider Issue 12)

The Board finds that the Intermediary properly allowed additional home office administrative costs following the submission of supporting documentation.

Issue 12. Was the Provider's request for costs incurred in settling the cost reports after termination from the Medicare program proper? (Provider Issue 11)

The Board finds that these termination costs should be claimed in the Provider's 1999 terminating cost report. The Board finds no basis to add these costs to the fiscal year at issue.

BOARD MEMBERS PARTICIPATING:

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

DATE: September 26, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman