PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D14

PROVIDER -
Riverview Center for Jewish Seniors
Pittsburgh, Pennsylvania

Provider No.: 39-5526

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Highmark Medicare Services

DATE OF HEARING -
April 23, 2007

Cost Reporting Period Ended –
June 30, 1998

CASE NO.: 01-0215

INDEX

ISSUE:

Whether the Intermediary's adjustments to remove Nursing Administration, Medical Records, and Social Services allocation statistics from the Provider's ancillary cost centers on the Medicare cost report were proper?

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 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.

An essential element of the Medicare cost reporting process is determining how much of a provider's allowable cost should be apportioned to the Medicare program. This process is known as "cost finding." Through the cost finding or "step-down" process, a facility's overhead costs such as building depreciation, administrative and general expenses, and nursing administration are allocated to the revenue-producing departments such as radiology, laboratory, and the therapy cost centers. Medicare reimbursement principles set forth the allocation bases (square footage, accumulated cost, etc.) upon which, as well as the order in which, the non-revenue producing cost centers are stepped down to the revenue-producing cost centers.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Riverview Center for Jewish Seniors (Provider) is a 364-bed skilled nursing facility located in Pittsburgh, Pennsylvania. When the Provider prepared its Medicare cost report for the fiscal year ended June 30, 1998, it allocated Nursing Administration, Medical

Records, and Social Services costs to the routine and ancillary cost centers. These allocations are based on the Provider's representation that staff time was spent working in, and contributing to these cost centers. Veritus Medicare Services (Intermediary) reviewed the Provider's cost report and concluded that allocation of these overhead costs to ancillary cost centers was improper.[1] The Intermediary, therefore, adjusted the Provider's cost report by removing the statistics from the ancillary cost centers leaving an allocation to only the routine cost centers.

The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $209,153 ($136,013 for Nursing Administration, $27,479 for Medical Records, and $45,661 for Social Services).[2]

The Provider was represented by Donald R. Reavey, Esquire, of Capozzi & Associates, P.C. The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that its ancillary cost centers clearly benefit from the services of its Nursing Administration, Medical Records and Social Services cost centers.[3] The need for allocation of Nursing Administration costs to the ancillary cost centers results, in part, from Federal statutes that require a registered nurse to conduct or coordinate resident assessments and that require the Provider to develop a comprehensive health care plan for each resident. Also, under Pennsylvania state law, the Director of Nursing is responsible for general supervision which involves implementing a resident's personal health program to assure that preventive measures, treatments, medications and other prescribed health services are properly carried out and recorded. Therefore, the costs of the Director of Nursing become an indirect cost of those ancillary services.[4]

Similarly, the Director of Medical Records and the Director of Social Services provide services that benefit the ancillary cost centers. The Director of Medical Records assures that all services ordered are actually provided, that all medical records including those for therapy services are complete, and that the therapy services data used for resident assessments is correct.[5] The Director of Social Services works with ancillary cost center staff to provide progress reports to residents' families, to coordinate family training and education for participation in therapy, and to order physical therapy and home medical equipment that the residents will need upon discharge. The Provider asserts that if these individuals did not perform these services, the ancillary departments would have to staff

[1] Veritus Medicare Services is now Highmark Medicare Services.
[2] Intermediary's Position Paper dated January 25, 2006.
[3] Provider's Post-Hearing Brief at 2.
[4] Provider's Post-Hearing Brief at 3. Transcript (Tr.) at 107-121.
[5] Provider's Post-Hearing Brief at 5. Tr. at 65-87.

these functions themselves to assure the accuracy and completeness of their own records and support any charges made for those services.[6]

The Provider also contends that it has presented sufficient documentation to support the subject allocations. Exhibit P-9 contains a summary of each time study performed to support the allocations of Nursing Administration, Medical Records and Social Services to the ancillary cost centers. The data shown on the time summaries tie to the statistics shown on the Provider's cost report, and the hours reported are supported by testimony of individuals who contributed to the time study and who compiled the summaries.

The Intermediary contends that Nursing Administration and Social Services cost are always considered routine service costs pursuant to program guidelines contained in Medicare's Provider Reimbursement Manual, Part I (CMS Pub. 15-1) §2203.1, entitled Routine Services in SNFs,[7] which states in relevant part:

> [t]o reduce the potential impact of unusual or inconsistent charging practices, the following types of items and services, in addition to room, dietary, medical social services, and psychiatric social services, are always considered routine in an SNF for purposes of Medicare cost apportionment, even if customarily considered ancillary by an SNF:
>
> All general nursing services. . . . (emphasis added).

The Intermediary also contends that in order to allocate time and costs to an ancillary department, there must be a corresponding responsibility over, or direct services performed by the non-revenue producing cost center for the ancillary cost center. With respect to the instant case, there is no evidence that the Provider's nursing administration, medical records or social services departments had any such supervisory responsibility over the ancillary departments or direct involvement in the delivery of ancillary services.[8] The only documentation supplied to support the allocations made was a schedule which summarized how individuals within the overhead departments in issue spent their time during the year under appeal. While these summaries show activities involving ancillary departments, they do not show that the individuals performed ancillary services; rather, testimony shows that the individuals were performing an ordinary part of routine patient care. No auditable documentation such as detailed time sheets for the Provider's employees were submitted in support of these summaries. Therefore, without auditable evidence of how the time allocations were made or what they were based on to substantiate the Provider's claim, no allocations to these ancillary departments should be allowed.

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[6] Id. Tr. at 26-49.
[7] Intermediary Position Paper at 11 and 14. Tr. at 16.
[8] Intermediary's Post-Hearing Brief at 3.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Regulations at 42 C.F.R. §413.24 require providers of health care services participating in the Medicare program to maintain adequate cost data to support their claim for reimbursement. In part, the regulation states:

> (a) *Principle.* Providers receiving payment on the basis on reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. (Emphasis added).
>
> (c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization . . .

Regulations at 42 C.F.R. §413.24(d)(1) address the step-down method of cost finding which is applicable to this case. The regulation states in relevant part:

> [a]ll costs of nonrevenue-producing centers are allocated to all centers that they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue–producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first . . . .

Worksheets B, Part 1 and B-1 of the Medicare Cost Report provide the mechanics for implementing the step-down method of cost finding. The instructions for completing these worksheets are contained in section 3524 of Medicare's Provider Reimbursement Manual, Part II (CMS Pub. 15-2).[9] In part, the instructions state:

> Worksheet B, Part I provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, ancillary service cost centers, inpatient routine service cost centers, outpatient service cost centers, special purpose and other reimbursable cost centers, and non-reimbursable cost centers. The total direct expenses are obtained from Worksheet A, column 7.

[9] See also: CMS Pub.15-1 §2313, CHANGING BASES FOR ALLOCATING COST CENTERS OR ORDER IN WHICH CENTERS ARE ALLOCATED.

> Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B, Part I. . . .
>
> The statistical basis shown at the top of each column on Worksheet B-1 is the recommended basis of allocation of the cost center indicated.

The Provider, on its as-submitted cost report, assigned allocation statistics to both routine and ancillary service cost centers for the general service costs of Nursing Administration, Medical Records and Social Services. The Intermediary adjusted the Provider's cost report by eliminating the statistics assigned to the ancillary departments. These adjustments resulted in all of the costs of Nursing Administration, Medical Records and Social Services being allocated to routine service areas thereby reducing the Provider's program reimbursement.

Initially, the Intermediary based the adjustments on its general understanding of 42 C.F.R. §413.24 and CMS Pub. 15-1 §2203.1, which explain that social services and general nursing services are always considered routine services in a skilled nursing facility. The Intermediary's witness testified:

> [w]hat we did was any stats [statistics] that were allocated to the ancillary cost centers when I was scoping the audit at desk review, I removed those stats from the ancillary cost centers based on the regulations at C.F.R. §413.24 on proper cost apportionment, and also on PRM [Provider Reimbursement Manual] references [section] 2203.1. That was standard for us to remove nursing administration statistics out of the ancillary cost centers just to reduce those to zero.[10]

Ultimately, however, the Intermediary conceded that, if properly documented, these allocations to ancillary departments could be appropriate. In the Intermediary's Post-Hearing Brief at page 4, it states:

> [t]he Provider has included summary sheets at Exhibit P-9, which summarize the time spent by individuals within the nursing administration, medical records, and social services departments during the year under appeal. However, the provider has not supplied any documentation to support those summaries. While the Provider has also supplied copies of instructions for filling out the time sheets, and copies of actual time sheets, these are documents from other providers and have no relationship to the summaries used for allocation of costs in this case (Transcript @ 25 and 88-89).

The Board agrees with the Intermediary. The record shows that the Provider did not furnish individual time sheets. Instead, the Provider submitted "sample" time sheets and instructions from other unidentified providers to illustrate the way the time sheets were

[10] Tr. at 225 lines 5-16.

completed and the instructions given for their completion. The instructions emphasized the importance of identifying time spent relating to the ancillary areas in order to increase Medicare reimbursement.

The Board finds that summaries are no substitute for auditable documentation, and it is clearly the Provider's responsibility to maintain sufficient records to support its claim pursuant to 42 C.F.R. §413.24. Although, the Provider asserts that the testimony of its witnesses cures the lack of auditable source documentation, the Board is not persuaded that the statistical data furnished by the Provider at Exhibit P-9 is, in fact, an accurate compilation of the time spent providing services to ancillary departments.

DECISION AND ORDER:

The Intermediary's adjustments removing Nursing Administration, Medical Records, and Social Services allocation statistics from the Provider's ancillary cost centers were proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

DATE: January 23, 2008