PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D28

PROVIDER –
Quality Lifestyles of Mesa
Mesa, Arizona

Provider No.: 03-7205

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING –
February 27, 2008

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 02-0463

INDEX

ISSUE:

Whether the Intermediary properly reclassified professional fees from the Administrative & General (A&G) – Reimbursable cost center to the A&G-Shared cost center for the cost reporting period ending December 31, 1999.

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:

Quality Lifestyles of Mesa (Provider) is a Medicare certified home health agency located in Mesa, Arizona. The Provider offered home health services and private duty nursing services to homebound patients throughout the Mesa area. The Provider submitted its fiscal year ending December 31, 1999 cost report to Cahaba Government Benefit Administrators (Intermediary). The Intermediary performed a desk review on the Provider's cost report and proposed an adjustment to reclassify professional fees from the A&G-reimbursable cost center, cost center 5.02 (allocated only to the Medicare reimbursable cost centers) to the A&G-shared cost center, cost center 5.01, (allocated to all cost centers). The Intermediary issued the NPR on September 20, 2001. The adjustment resulted in a cumulative reduction of Medicare reimbursement of approximately $15,390[1].

[1] Provider's Position Paper, page 4.

The Provider appealed the adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Paula Ward of NurseCore of Phoenix. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider argues that the consulting expenses under dispute were properly classified on the as-filed cost report as an A&G-reimbursable cost, which only allocated to the Medicare reimbursable cost centers. The Provider asserts that the professional fees were paid to Ciarletta & Associates, Inc., the Provider's Medicare consultants for the preparation of Medicare cost reports, analysis of audit adjustments to Medicare cost reports, requests for Medicare extended repayment plans, an impact analysis of the Interim Payment System (IPS) and for responding to Intermediary auditor requests for information. The Provider asserts that the fees incurred relate only to the Medicare program and would not have been incurred without participation in the Medicare program. The Provider also argues that the fees in no way benefit the non-reimbursable private duty nursing line of business. Therefore, the Provider reasons that consulting fees should be allocated only to the Medicare reimbursable cost centers and not to all the cost centers, which includes the private duty nursing cost center, cost center 17.

The Provider asserts that the Medicare cost reporting instructions at CMS Pub. 15-2 §3214 specifically allow for the Provider's treatment of the consulting fees. The manual instruction states, in part:

> HHAs may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two possible methodologies. . . . Under the first methodology (also referred to as option 1), the HHA must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate **exclusively** to either the HHA reimbursable or HHA nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. . . . (Emphasis added)

The Intermediary asserts that review of the invoices relating to the professional fees revealed that the expenses were for budgeting and other types of financial analysis as well as for Medicare cost report planning and preparations. The Intermediary further asserts that the planning and preparation of the Medicare cost report benefits the entire organization, as it addresses apportionment of cost between the Medicare and non-Medicare portions of the business. It is the Intermediary's position that the law, regulations and manual instructions do no authorize 100% reimbursement for this type of expenditure; rather two regulations support its position that the professional fees should be shared costs which are allocated among all cost centers.

42 C.F.R. §413.9(b)(1) states in relevant part:

> The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

The issue of cost apportionment is also addressed at 42 C.F.R §413.53(a):

> Total allowable costs of a provider will be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by the program beneficiaries. . . .

The Intermediary also cites PRRB Decision No. 85-D97, The Arlington Hospital vs. Blue Cross and Blue Shield Association/Group Hospitalization, Inc., August 19, 1985, in which the Board found, and the Administrator affirmed, that the Provider is not entitled to 100% reimbursement for the accounting fees incurred for the preparation of its Medicare cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and the parties' contentions, the Board finds and concludes as follows:

The Intermediary reliance on Arlington in support of its reclassification of the professional fees from A&G-reimbursable to A&G-shared cost centers is misplaced. CMS Pub. 15-2 §3214 was revised with Transmittal No. 2, dated May 1, 1996. This change, which was effective for cost reporting periods beginning on or after September 30, 1996, allowed for the fragmentation of the A&G cost center on home health agency cost reports. The three types of fragmented categories allowed were (1) 100 percent HHA reimbursable costs, (2) 100 percent HHA nonreimbursable costs, and (3) A&G shared costs.[2]

The fiscal year under appeal in this case is December 31,1999. Therefore, the above manual provision was effective for the year in issue, and fragmentation of A&G is permissible. The PRRB's ruling in Arlington, and the Administrator's subsequent affirmance, were prior to the HHA manual change that allowed for fragmenting of the A&G cost centers.

As the manual allows for the fragmentation of A&G, the question before the Board is in which category the contested costs should fall. If the costs were included in the A&G-reimbursable cost center, the costs would be allocated only to the Provider's Medicare reimbursable cost centers, which included Skilled Nursing Care, Physical Therapy, Occupational Therapy, Speech Pathology, Medical Social Services, Home Health Aide

[2] CMS Pub. 15-2 §3214

and Supplies. If the costs were grouped in the A&G-shared cost center, the costs would be allocated to all the reimbursable cost centers, as well as the one non-reimbursable cost center, Private Duty Nursing.

The Board finds that the professional fees paid for Medicare cost report preparation, Medicare cost limit analysis, IPS breakeven analysis, Medicare cost report extended repayment plan preparation and Medicare cost report audit adjustment review relate only to the cost centers reimbursed by Medicare. If not for these Medicare reimbursable cost centers and the related Medicare reimbursement, the professional fees would not have been incurred. The Board finds the non-reimbursable cost center, Private Duty Nursing, neither caused any of the professional fees to be incurred nor benefited from any of the work performed. The Board finds that $13,622[3] of the professional fees should be allocated only to the Provider's reimbursable cost centers thereby ensuring that the Medicare program will reimburse the Provider its share of these costs based upon the Medicare utilization in the reimbursable cost centers.

DECISION AND ORDER:

The Intermediary improperly reclassified $13,622 of professional fees from A&G-reimbursable to A&G-shared costs. The Intermediary's adjustment should be modified to reclassify only $366 from A&G-reimbursable costs to A&G-shared costs.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: May 20, 2008

[3] Of the $13,988 of professional fees reclassified from A&G-reimbursable to A&G-shared, the Provider has conceded that $366 could relate to services that benefit the entire facility, not only the Medicare reimbursable departments. Therefore, the amount of professional fees that remain in contention is $13,622.