PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D7

PROVIDER -
Pleasant Care Corporation Utilization Review Cost Group

Provider Nos.: Various
(See attached Schedule of Providers)

vs.

INTERMEDIARY -
Wisconsin Physicians Service
(formerly Mutual of Omaha Insurance Company)

DATE OF HEARING -
June 6, 2007

Cost Reporting Periods Ended – Various

CASE NO.: 05-1420G

INDEX

ISSUE:

Whether the Intermediary's adjustment to utilization review costs was 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 under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

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. §§405.1835-405.1837.

42 U.S.C. §1395xx(a)(1) authorizes the Secretary to determine criteria for distinguishing those services rendered in hospitals or skilled nursing facilities which constitute professional medical services that are rendered by a physician to an individual patient and which may be reimbursed as physicians' services under part B versus those professional services that are rendered for the general benefit of patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis. For those services that are determined to be for the general benefit of patients, 42 U.S.C. §1395xx(a)(2)(B), authorized the Secretary to establish through regulation the "reasonable compensation equivalent" ("RCE") limits beyond which a provider's costs for such services may not be reimbursed. 42 C.F.R. §415.70 implements the RCE limits on the amount of compensation paid to physicians by providers that is required by statute. The issue in dispute in this appeal is whether the Intermediary properly adjusted the Providers' utilization review costs when they applied the RCE limits to these costs.

42 U.S.C. §1395f(b) requires that the amount paid to a provider must be the lesser of either the reasonable cost or the customary charges with respect to the services. A

provider is required to maintain adequate records for reasonable cost determination purposes pursuant to 42 U.S.C. 1395g(a)[1], which states:

> ". . . no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

CMS publishes a Provider Reimbursement Manual ("PRM")(CMS Pub. 15-1) which provides guidelines and policies to implement the Medicare regulations. Section 2126 of the PRM addresses utilization review and states: "[c]osts incurred by the provider in connection with utilization review are includable in reasonable costs. . ." Section 2126.4A of the PRM addresses record keeping for utilization review costs and states:

> "Section 1815 of the Act states that a provider must maintain adequate records for reasonable cost determination purposes. Consequently, for utilization review compensation received by physicians or other persons to be recognized as an allowable cost, a provider must keep adequate records to determine the reasonableness of its payments for services identified as being exclusively related to utilization review activities. Only the actual time spent in rendering utilization review services should be recorded. . . "

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pleasant Care Corporation Utilization Review Cost Group ("Providers") is comprised of 32 for-profit, skilled nursing facilities located in California (with the exception of one located in Nevada.) During the cost reporting years in dispute, the Providers incurred utilization review costs which were paid to physicians for attendance at utilization review meetings. The Providers claimed these utilization review costs on their as-filed cost reports for the purpose of obtaining reimbursement.

Mutual of Omaha Insurance Company ("Intermediary") examined the Providers' cost reports and issued either a Notice of Amount of Program Reimbursement ("NPR") or Notice of Correction – Program Reimbursement ("RNPR"), as appropriate. The Intermediary adjusted the claimed utilization review costs which were paid to physicians in each of the thirty-two skilled nursing facilities cost reports. All pass-through utilization review costs were removed from twenty-two of these cost reports as the Intermediary received no documentation from the Providers to support the costs. However, the Intermediary did receive supporting documentation for ten of the cost reports, and allowed the utilization review costs to the hours which it felt were supported by the documentation. The Intermediary also applied the RCE limits to these utilization review costs which were paid to the physicians.

[1] See 42 C.F.R. §413.24.

The Providers were represented by Paul R. Gulbrandson, CPA. The Intermediary was represented by Stacey Hayes and Terry Gouger, C.P.A. of Mutual of Omaha Insurance Company.

PROVIDERS' CONTENTIONS:

The Providers' response to the lack of documentation assertion for the 32 cost reports in this appeal is as follows: 10 cost reports are properly documented, 5 cost reports did not have utilization review committee ("URC") minutes and are properly disallowed, and 17 cost reports should be allowed because the Intermediary did not timely request the documentation in dispute. The Providers assert that the supporting data for the 17 cost costs reports was available in their corporate office for inspection and review by the Intermediary, and that the Intermediary did not take advantage of the opportunity to inspect these records when available at the time of the desk audits.

The Providers contend that the data provided to the Intermediary for 10 of the 32 cost reports was sufficient in that it included documentation of URC meeting minutes, as well as documentation supporting the total monies paid to the physicians who attended these URC meetings. The Providers also contend that the Intermediary failed to adhere to proper Government auditing standards known as the "Yellow Book" requirements,[2] and that the Intermediary did not provide adequate support to the Providers to justify their adjustments.

Additionally, the Providers assert that the Intermediary improperly applied RCE limits to the utilization review costs which were reimbursed. The Providers argue that 42 U.S.C. §1395xx(a)(2)(B) only applies to hospital based physicians providing services impacting the general patient population, and that the URC physician services are patient specific and, do not fall into this category. The Providers indicate that the payments for utilization review costs should have been fully reimbursable without the application of the RCE limits as the physicians providing the utilization review services were not full time employees of the Provider, and application of RCE limits grossly understates its reimbursement. The Providers further argue that the regulation implementing RCE limits found at 42 C.F.R. §415.70 and the Federal Register dated May 5, 1997, do not apply to utilization review costs paid to physicians.

INTERMEDIARY'S CONTENTIONS:

The Intermediary responds that the Providers failed to provide adequate cost data from their financial and statistical records for verification by its auditors as required by 42 C.F.R. §413.24. The Intermediary contends that the Providers failed to follow their own record retention policy which requires that utilization review meeting minutes be kept for more than three years.[3] The Intermediary also refers to the PRM §2126.4A which states that providers must keep specific adequate records regarding utilization review service costs to support their allowance.

---

[2] As referenced by the Provider as GAO-03-673G. See Providers' Post Hearing Brief at 3.
[3] Transcript (Tr) at 171-172.

The Intermediary asserts that they requested documentation from the Providers for each of the 32 cost reports at issue during the time of the desk review but the Providers did not produce documentation necessary to support the utilization review costs as reported in 22 of the 32 cost reports at issue. It adjusted 10 cost reports to reflect allowance for the hours supported by the documentation. The Intermediary states that qualified auditors performed the reviews and requested the necessary information regarding costs in a timely fashion.[4]

The Intermediary also argues that the application of RCE limits was proper pursuant to 42 U.S.C. §1395xx(a)(2)(B) which requires that the cost for services furnished by physicians to providers that are paid by Medicare on a reasonable cost basis are subject to the established RCE limits. The Intermediary refers to 62 Fed. Reg. 24,483 (1997), which also states that RCE limits are applicable to all services furnished by physicians to providers that are not covered by PPS or per resident payments for graduate medical education and are paid by Medicare on a reasonable cost basis, including those services provided in skilled nursing facilities.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the Intermediary's adjustment of the Providers' utilization review costs was proper.

The Board finds that the Intermediary properly concluded that there was insufficient documentation to support the disallowed utilization review costs. The Providers failed to meet general statutory, regulatory and program manual documentation requirements in this case. Simply verifying that a payment was made to a physician does not ensure that the payment was reasonable or that it was for utilization review services. The limited documentation that was submitted by the Providers varied widely in detail. Extreme variances in the hourly rates for reimbursement are evident which raises further concern whether the claimed costs are reasonable and whether services other than utilization review were also provided.[5]

42 U.S.C. §1395g prohibits any payment from being made to a provider unless the provider has furnished "such information as the Secretary may request in order to determine the amount due the provider."[6] 42 U.S.C. §1395f(b) requires that the amount paid to a provider must be the lesser of either the reasonable cost or the customary charges with respect to the services. The PRM at §2126.4A, states "for utilization review compensation received by physicians or other persons to be recognized as an allowable cost, a provider must keep adequate records to determine the reasonableness of its

---

[4] Tr. at 15-17.

[5] Tr. at 172. See also Intermediary's Exhibit I-9.

[6] Providers must maintain "sufficient financial records and statistical data for proper determination of costs payable under the program." 42 C.F.R. 413.20. Adequate cost data must also be provided pursuant to 42 C.F.R. 413.24 which states "Providers receiving payment on the basis of 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."

payments for services identified as being exclusively related to utilization review activities." The PRM provides detailed instruction as to the specific records which are required to establish allowable compensation for these costs.

The Board notes that while the Providers' case is largely based upon its critique of the Intermediary's audit methodology and technique, the NPRs and RNPRs put the Providers on notice to maintain adequate documentation. After the NPRs and RNPRs were issued, the Providers were given additional time and ample opportunity to provide the required documentation to support their claimed utilization review costs. Accordingly, the Providers' critique, regardless of the merits, does not impact the ultimate fact that insufficient documentation was submitted by the Providers to support the utilization review costs claimed.

42 U.S.C. §1395xx(a)(1) authorizes the Secretary to established by regulation criteria to distinguish between professional medical services reimbursed under Part B of the Medicare program from those professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and reimbursed on a reasonable cost basis. For the latter, services which are determined to be reimbursable on a reasonable cost basis, 42 U.S.C. §1395xx(a)(2)(B) authorizes the Secretary to establish through regulation the RCE limits beyond which a provider may not be reimbursed. For the purposes of applying the RCE limits, physician compensation costs means "monetary payments, fringe benefits, deferred compensation, and any other items of value (excluding office space or billing and collection services) that a provider or other organization furnishes a physician in return for the physician services." 42 C.F.R. §415.60(a).

Utilization review must be performed by the provider in order to participate in the Medicare program. The Provider Reimbursement Manual, (CMS Pub. 15-1), § 2126, requires reimbursement for utilization review costs be made only as part of the provider's reasonable costs. Utilization review costs are to be included in the Provider's reasonable costs for the purpose of comparing them with customary charges. The Board finds no support for the Providers allegation that 42 U.S.C. §1395xx(a)(l)(B) and the implementing regulations regarding the application of RCE limits clearly state that RCE limits do not apply to utilization review physicians' service costs. The Federal Register dated May 5, 1997, states "If a physician receives any compensation from a provider for his or her physician services to the provider (that is, those services that benefit patients generally), payment to those affected providers for the costs of such compensation is subject to the RCE limits."[7] Furthermore, the Board finds no additional authority to suggest that utilization review costs paid for services furnished by physicians to providers are not subject to RCE limits. The utilization review costs at issue in this case were properly determined to be reimbursable on a reasonable cost basis subject to the RCE limits.

[7] 62 Fed. Reg. 24,483 (1997).

The Board also notes the Providers' contention that the Intermediary should have called a certain employee as a witness.[8] However, the Intermediary had no obligation to call any witness. The Providers had the opportunity to subpoena any Intermediary witness it wanted to testify and did subpoena an Intermediary witness. Moreover there is no indication that such a witness' testimony would have provided information which would change the decision as the cost documentation submitted was clearly insufficient.

DECISION AND ORDER:

The Intermediary's adjustment of utilization review costs was proper. The Intermediary properly disallowed the utilization review costs which lacked proper documentation. The Intermediary properly applied the RCE limits to the allowed utilization review costs for the cost report years at issue in this appeal. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: January 23, 2009

[8] Tr at 37-39.