PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D10

PROVIDER -
Genesis Health 96 Salaries of Therapists Group

Provider No.: Various

vs.

INTERMEDIARY -
BlueCross and BlueShield Association/ First Coast Service Options, Inc.

DATE OF HEARING -
July 15, 2009

Cost Reporting Periods Ended - Various

CASE NO. 98-3417G

INDEX

ISSUE:

Whether the Intermediary's deletion of therapy costs from line 25, column 9 of Worksheet B-1 of the Providers' Medicare cost reports is proper and in accordance with Medicare cost reporting practices and procedures.

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 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 and 405.1837.

The objective of the Medicare cost reporting process is to determine how much of the a provider's allowable costs are to be reimbursed by the Medicare program. That is accomplished through a process known as "cost finding." Cost finding includes a step-down process through which a hospital's overhead costs (e.g., building depreciation, administrative and general expenses, and nursing administration) are allocated to revenue-producing departments such as radiology, laboratory and physical therapy. Medicare guidelines specify the sequence of allocation as well as the bases for allocation (square footage, accumulated costs, hours of service, etc.).

Most providers use the step-down method of cost finding which is described in 42 C.F.R. §413.24(d)(1). The overhead costs are allocated to the revenue-producing cost centers on Worksheet B of the cost report, using bases of allocation shown on Worksheet B-1. The recommended allocation basis for nursing administration costs is direct nursing hours of service.[1]

[1] Exhibit I-8.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The 30 providers in this group (the Providers) are skilled nursing facilities owned and operated by Genesis Health Ventures, Inc. When the Providers prepared their Medicare cost reports instead of using the suggested statistic of direct nursing hours to allocate nursing administration, they utilized a combination of direct nursing salaries and therapy salaries. As a result, nursing administration costs were allocated to those cost centers in which there were direct nursing salaries and also to cost centers in which there were therapy salaries. Veritus Medical Services (the Intermediary) adjusted the Providers' allocation of nursing administration costs by eliminating the therapy salaries from Worksheet B-1, column 9.[2]

The Providers appealed the Intermediary's adjustment to the Provider Reimbursement Review Board (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 $390,685.

The Providers were represented by Louis J. Capozzi, Jr., Esquire and Bruce G. Baron, Esquire of Cappozi & Associates, P.C. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that there is no dispute that their prior intermediary, Aetna, approved the use of both nursing and therapy salaries to allocate nursing administration costs. The Providers indicate that beginning in 1990 they used the approved statistic on their filed cost reports and that there were no adjustments to their cost reports for this issue until the current Intermediary's decision to challenge this matter for some, but not all, of Genesis' facilities in the 1996 fiscal year. The Providers also point out that this same statistic was approved for and allowed in audits for the largest Medicare provider of skilled nursing facilities, Beverly Enterprises (Beverly). The Providers indicate that without any prior notification the Intermediary disallowed the allocation basis attributable to therapy salaries due to lack of documentation to support any such allocation.

The Providers refer to CMS Pub. 15-1 §2313 concerning approval of allocation statistics which states that "[w]here the intermediary approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods unless the intermediary approves a subsequent request for change by the provider." The Providers also argue that the manual does not require the provider to maintain documentation to support any prior required statistic once the new allocation statistic has been approved. The

[2] Prior to fiscal year 1996, the Providers' intermediary was Aetna Insurance Company (Aetna or previous intermediary). Veritus Medical Services was subsequently replaced by the current fiscal intermediary, First Coast Service Options, Inc.

Providers assert that the Intermediary is violating the consistency requirement of CMS Pub. 15-1 §2313 by establishing documentation requirements it was not obligated to maintain once it received approval for the new statistic. Extendicare 1996 Insurance Allocation Group v. Blue Cross Blue Shield Association/United Government Services, PRRB Dec. No. 2000-D88, September 26, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,573, declined rev., CMS Administrator, November 21, 2000.

The Providers indicate that the decision in Mercy Home Health v. Leavitt, 436 F.3d 370 (3rd Cir. 2006), upholding the CMS Administrator's decision that providers have to articulate a valid rationale to support their methodologies and that prior approval cannot negate Medicare cost principles prohibiting cost shifting, is distinguishable from this case. The Providers assert that in this case they have articulated a valid rationale supporting their methodology and there is no evidence of improper cost shifting. The Providers also contend that previous cases have supported the allocation of nurse administration costs using nursing hours or nursing salaries without additional time studies. Christ the King Manor v. Blue Cross Blue Shield Association/Veritus Medicare Services, CMS Administrator Decision, Medicare and Medicaid Guide (CCH) ¶ 80,974, February 15, 2003 (Christ the King Manor) (staff development coordinator reclassified to nursing administration and allocated on the basis of nursing hours); Southwestern Nursing Home and Rehabilitation Center v. Blue Cross Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 2001-D28, May 11, 2001, Medicare and Medicaid Guide (CCH) ¶ 80,665, declined rev., CMS Administrator June 27, 2001 (Southwestern Nursing Home) (Director of Nursing costs reclassified to nursing administration and allocated on the basis of nursing salaries). In the instant case, the Intermediary does not object to the use of nursing salaries to allocate nursing administration costs but only disallowed the inclusion of therapy salaries in the statistic. The Providers point out that the Board has previously indicated that where nursing administration is actually involved in therapy services, allocation of nursing administration to ancillaries is proper. Twining Village v. Blue Cross Blue Shield Association/Veritus Medicare Services, PRRB Dec, No. 2004-D19, April 30, 2004, Medicare and Medicaid Guide (CCH) ¶ 81,154, declined rev., CMS Administrator, June 18, 2004 (Twining Village).

The Intermediary's sudden change in position is contrary to its interpretation in prior year audits. The Providers state that the Secretary's discretion is broad but does not grant intermediaries a license to treat like cases differently. If the Medicare Act, regulations and manual provisions permitted the statistic from the early 1980s through 1995, then the Intermediary cannot change the application of the rules without rulemaking. The change in treatment here is sudden and unexplained, arbitrary and capricious and does not take into account the Providers' legitimate reliance on the CMS Pub. 15-1 §2313 approval of the statistic in this case. See Smiley v. Citibank, N.A., 517 U.S. 735, 742 (1996) (Sudden and unexplained change or change that does not take account of legitimate reliance on prior interpretation may be "arbitrary, capricious [or] and abuse of discretion").

The Providers assert that the Intermediary cannot suddenly impose an irrebuttable presumption against any allocation of nursing administration to ancillary cost centers because nursing

administration services are always considered routine under CMS Pub. 15-1 §2203.1. The Providers assert that the Intermediary's reliance on CMS Pub. 15-1 §2203.1 is misplaced because the citation only involves "general nursing services" and not nursing administration. In addition, this Intermediary has conceded before the Board that, if properly documented, allocation of nursing administration costs to ancillaries could be appropriate. Riverview Center for Jewish Seniors v. Blue Cross and Blue Shield Association/Highmark Medicare Services, PRRB Dec. No. 2008-D14, January 23, 2008, Medicare and Medicaid guide (CCH) ¶ 81,876, declined rev., CMS Administrator, February 26, 2008 (Riverview Center for Jewish Seniors). The Providers also indicate in this case, the Intermediary even rejected such allocations where they are supported by time studies.[3]

The Intermediary contends that nursing administration is responsible for directing the nursing personnel. While the administrative personnel may be involved in various areas of the skilled nursing facility as they relate to the care of a patient on a routine basis, that is still part of routine care. The Intermediary indicates that the cost reporting instructions at CMS Pub. 15-2 §1313 shows that the recommended basis for allocation of nursing administration to be direct nursing hours of service.[4]

The Intermediary states that the role of the director of nursing in coordinating the overall care of patients does not justify the allocation of nursing administration costs to ancillary cost centers. While such coordination is expected, it does not mean that nursing administration is responsible for those ancillary departments. Furthermore, testimony concerning interaction and collaboration with the therapy department indicated that only a couple of hours per week were spent in this activity.[5] The testimony showed that the director of nursing developed and maintained nursing service objectives; participated in the recruitment and hiring of nursing personnel; assigned duties and delegated responsibilities to nursing personnel; evaluated the performance of nursing personnel; and participated in firing nurses; however, these duties did not extend to the therapy department.[6] For the therapy department, these duties were performed by the nursing home administrator.[7]

The Intermediary points out that previous Board decisions emphasize that the regulation at 42 C.F.R. §413.24 and manual provision at CMS Pub. 15-1 §2306.1 require allocation of costs of non-revenue producing centers to all cost centers which they serve. That burden is on the provider to establish that the costs of the non-revenue producing center directly benefit any ancillary department. In Southwestern Nursing Home, supra, the Board found that the provider did not prove that the director of nursing was responsible for all aspects of patient care, including ancillary services. Also, in Twining Village, supra, the Board held that there was no support for the provider's contention that the documentation justified the allocation of nursing

[3] Exhibit P-12.
[4] Exhibit I-7 and I-8.
[5] Transcript (Tr.) at 137.
[6] Tr. at 113-114.
[7] Tr. at 134.

administration to the ancillary cost centers. The Board noted that job descriptions and organizational charts did not document any responsibility for the therapy department or actual time spent in that department by nursing administration personnel. The Intermediary concludes that to allocate time and costs to an ancillary department there must be documented responsibility over or direct services performed by, in this instance, nursing administration to the ancillary departments. In this case, the Providers have not provided sufficient supporting documentation of any supervisory responsibility for ancillary departments on the part of nursing administration.

The Intermediary also states that the Providers cannot rely on the presumed approval of their methodology by the previous intermediary because the previous intermediary decision to approve it was wrong.[8] The regulations and manual instructions are clear concerning the proper allocation of nursing administration costs and the Intermediary is bound to apply them. The Intermediary asserts that the regulations and guidelines concerning reopening of costs reports, 42 C.F.R. §405.1885 and CMS Pub. 15-1 §2931 allow an intermediary to reopen and reverse a final determination in order to correct an error. The Intermediary also notes that when it took over from the previous intermediary it had to complete a number of outstanding Genesis provider audits under budget and time constraints. As a result, a number of cost reports were settled without audit and the adjustment at issue in this case was not made to all Genesis providers. The fact that not all cost reports were adjusted does not change the fact that the Providers' treatment of the cost for the providers in this group was incorrect.[9]

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 procedure for making a change to the allocation basis for a particular cost center is specified at CMS Pub. 15-1 §2313. It states that:

> When a provider wishes to change its statistical allocation basis for a particular cost center and/or the order in which the cost centers are allocated because it believes the change will result in more appropriate and more accurate allocations, the provider must make a written request to its intermediary for approval of the change ninety (90) days prior to the end of that cost reporting period.
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> The intermediary's approval of a provider's request will be furnished to the provider in writing within sixty (60) days of receipt of the request. Where the intermediary approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost

[8] Tr. at 364-366.
[9] Tr. at 315-316.

> reporting periods unless the intermediary approves a subsequent request for change by the provider. The effective date of the change will be the beginning of the cost reporting period for which the request has been made.

(Emphasis added).

The Board agrees with the Providers that where an intermediary has given explicit prior approval, the provider should be able to rely on it, even if the intermediary changes its mind. See Extendicare, supra, (citing Chicago Lakeside Hospital v. Aetna Life Insurance Company, PRRB Dec. No, 89-D68, September 27, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,208, affirmed with modification, HCFA Administrator, November 20, 1989). The Board notes, however, that in both of these cases the intermediary approvals were in writing. As noted in CMS Pub. 15-1 §2313 above, the provider must make a written request for approval of the change and must provide a reasonable justification for the change which should include any documentation that supports the allocation. In addition, the intermediary must approve the provider's request in writing. The Board observes that if a provider had followed that procedure there would be a record of what was requested -- the documentation presented to support the change and a statement from the intermediary as to what was approved and why. Absent a written request and approval, the burden is on the provider to demonstrate with sufficient auditable documentation that nursing administration did in fact provide services to the therapy department to justify the allocation.

In this case, the Providers' witness testified that the request to change the allocation statistic, as well as the approval from the previous intermediary, was made verbally at a meeting.[10] No documentation was presented by the Providers to support their request.[11] The stated reason for the change was that nursing administration had hands-on responsibilities within the therapy group and that the methodology previously used by the Providers no longer applied.[12] It was also stated that the Providers' operating arrangement and philosophy, though not the same as Beverly, did focus on rehabilitation and getting patients home quickly and, therefore, it was appropriate to change the allocation to be consistent with what the previous intermediary had approved for Beverly.[13] The Providers' witness stated that he was unaware of what, if any, documentation or proof Beverly submitted in order to obtain approval from the previous intermediary.[14] The Providers also testified that they began using the new method in 1990 and did not receive any adjustments concerning this issue from 1990 through 1995.[15]

The Board did not find any evidence in the record that the Providers properly obtained approval from its previous intermediary to change their allocation statistic. It was acknowledged that no

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[10] Tr. at 38-39.
[11] Tr. at 54.
[12] Tr. at 38.
[13] Tr. at 38-39.
[14] Tr. at 45-46.
[15] Tr. at 41-43.

written request was made and no written approval was granted by the previous intermediary.[16] As a result, the Board does not have any specific information regarding the basis of the Providers' request, if there was documentation to support the allocation, or what the previous intermediary actually approved. While there was testimony concerning the use of a similar statistic by Beverly, there is no documentation in the record concerning Beverly's request for approval, any approval it obtained or exactly what it reported on its cost reports. Finally, the Board notes that the mere lack of an adjustment by the previous intermediary by itself does not constitute approval since cost reports may be settled without audit.

Even though the Board finds that the Providers did not properly obtain approval to allocate nursing administration costs using therapy salaries, the Board disagrees with the Intermediary's argument that the allocation of nursing administration to ancillary departments per se violates the regulations and manual provisions. There was considerable testimony in the record that the role of nursing administration has increased in nursing facilities and includes managing and providing services to ancillary cost centers, over and above the usual role of communication and coordination of care with other ancillary departments. The Board also notes that in a number of cases, it has considered whether providers had sufficient auditable documentation to support their allocation of nurse administration costs to ancillary departments. See e.g., Southwestern Nursing Home, supra, Christ the King Manor, supra, Twining Village, supra, and Riverview Center for Jewish Seniors, supra.

The Providers in this case asserted that the Intermediary refused to consider the allocation, even where it was supported by time studies, because of the Intermediary's presumption that nurse administration costs only support nursing hours in routine cost areas.[17] The Providers presented what appear to be time studies,[18] conducted for one of the Providers in the group from January through September 1996 in which hours of nurse administration are allocated among the various areas of the facility including certified, non-certified and therapy areas. The Board finds, however, that, other than providing the reports for one provider in the group, the Providers did not explain the nature of the time study so the Board could determine whether it in fact supported their contentions, or if similar documentation for other Providers in the group was available. As a result, the Board finds that the Providers have still not submitted adequate documentation to support the allocation to therapy cost centers.

In summary, the Board finds that, because the Providers could not prove they obtained written approval of their allocation methodology, there is no evidence in the record to support the change in allocation and what was approved. In addition, the Providers did not present sufficient auditable documentation to support their allocation of nursing administration to therapy cost centers.

DECISION AND ORDER:

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[16] Tr. at 38-39.

[17] Providers' Post Hearing Brief at 12.

[18] Exhibit P-12.

The Intermediary's adjustment deleting therapy salaries from line 25, column 9 of Worksheet B-1 of the Providers' Medicare cost reports was proper. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: January 6, 2010