

# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D52

**PROVIDER –**  
Pleasant Care – Pomona  
Pomona, California

Provider No. 05-6241

**vs.**

**INTERMEDIARY –**  
Mutual of Omaha Insurance Company

**DATE OF HEARING -**  
September 25, 2002

Cost Reporting Period Ended  
June 30, 1998

**CASE NO.** 01-2455

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ISSUE:

Were the Intermediary's adjustments reclassifying the Medical Director cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pleasant Care-Pomona ("Provider") is a 231- bed Medicare certified Skilled Nursing Facility ("SNF"), located in Pomona, California. Mutual of Omaha Insurance Company ("Intermediary") was the Provider's Medicare Fiscal Intermediary. During the fiscal year under appeal, the Provider paid fees to a Medical Director for the utilization review ("UR") of the Provider's patient population.

The Intermediary issued a Notice of Program Reimbursement ("NPR") on September 27, 2000. The NPR contained audit adjustments which removed utilization review costs from direct reimbursement on the Medicare cost report Worksheet E, Part 1, and added that cost to the Administrative and General cost center. The Provider timely appealed the NPR to the Provider Reimbursement Review Board ("Board") on March 23, 2001. The Provider's filing met the jurisdictional requirements in accordance with 42 C.F.R. §§ 405.1835-405.1841. The Medicare reimbursement effect is approximately \$11,500.

The Provider was represented by Paul Gulbrandson, C.P.A., and the Intermediary was represented by Thomas Bruce, C.P.A., and Matt Pleggenkuhle, of Mutual of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that the Medical Director's fees in dispute were related to the UR process and therefore were properly categorized as filed. The Provider further contends that UR is a Medicare-only process and therefore should be fully reimbursable by Medicare. The Provider also made the following contentions:

- a. The Intermediary did not submit one iota of documentation with the related NPRs.
- b. The Intermediary actually performed an audit, but did not perform it properly.
- c. The Provider contends that it does not have to prove allowability until the Intermediary looks at the Provider's documentation.
- d. The Intermediary's requests for documentation were too burdensome.
- e. It is more economical for the Provider to travel to Baltimore than to provide photocopies of relevant documentation for two facilities

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not established the allowability of the Medical Director's UR expense as a direct cost on the Medicare Settlement Worksheet in accordance with the cost reporting instructions at CMS Pub. 15-II, §§ 3519 and 3534.1. These instructions specify that:

If the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician cost among all patients using the SNF.

The Intermediary argues that the Provider did not adequately document direct cost treatment and it is the Provider's responsibility to furnish support for the direct cost treatment of the claimed UR expense. The regulation at 42 C.F.R. § 413.24 states in part that: "[p]roviders receiving payment on the basis of reasonable cost must provide adequate cost data." The Intermediary points out that the Provider's representative confirmed that it is the Provider's responsibility to document that the expense should receive direct cost treatment.<sup>1</sup>

The Intermediary points out that it attempted to obtain the source documentation from the Provider to substantiate the allowability of the claimed expense. It requested additional information by letter including follow up letters, by discovery, and by telephone. However, the Intermediary never received the information.

The Intermediary points out that the Provider had previously acknowledged that it wasn't entirely confident that the records available would support the treatment requested on the as-filed cost report. In response to the Intermediary's July 15, 1998 letter requesting additional information, the Provider responded that "[t]hese costs represent the fees paid to physicians primarily for utilization review purposes. Unfortunately, I must admit that some of the facilities do not keep complete records of UR meetings."<sup>2</sup>

The Intermediary contends that its adjustment was appropriate in light of the Provider's unwillingness and/or inability to provide the documentation necessary to demonstrate the allowability of the expense.<sup>3</sup> Based upon the lack of documentation, the Intermediary removed the UR costs from the direct reimbursement line and added them back to the Administrative and General cost center, in accordance with the cost reporting instructions at CMS Pub. 15-II § 3519.

The Intermediary argues that based upon the evidence presented by the Provider to the Intermediary to support the categorization of the UR expense, the Provider did not substantiate that the expense qualified for direct reimbursement.

#### FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions and evidence presented, finds and concludes that the adjustment made by the Intermediary to the Medical Director's utilization review costs was proper.

The Provider has taken the position that the Intermediary did not come to the Provider facility to perform an on-site audit and therefore, the Provider does not have the responsibility of proving its claimed costs are allowable. The Provider's witness testified that: "[t]he way an audit works

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<sup>1</sup> Tr. at 155:3-155:11.

<sup>2</sup> Exhibit I-10, Tr. at 155:24-156:9.

<sup>3</sup> Tr. at 156:18 – 158:18

is the cost report is filed, the Intermediary comes in and the Intermediary looks at the documentation to prove that it is not allowable. The Provider doesn't have to prove it's allowable."<sup>4</sup>

The Provider relies on the "Yellow Book," the Intermediary's audit guidelines, in support of its position although it failed to make any reference to specific procedures or techniques it claims were violated. The Board finds that the audit guidelines do not shift the burden of proof to the Intermediary. The Board finds that the Provider was not in compliance with the Medicare regulation at 42 C.F.R § 413.24 - Adequate Cost Data and Cost Finding. That regulation states in part:

- (a) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data.

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- (b) 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.

The Board finds that the Intermediary made several attempts to obtain the necessary documentation. This was done prior to the finalization of the NPR as well as shortly before the hearing. The Provider did not respond and did not present documentation at the hearing to support its position.

The Provider's witness, employed as the Provider's Director of Reimbursement,<sup>5</sup> testified that "it was his understanding" that utilization review by medical personnel was conducted only for Medicare patients.<sup>6</sup> He represented that the records requested would have been "burdensome" to copy and send to the Intermediary but that if the Intermediary had come to the Provider's facility to audit, they would have been furnished at least a sample of records to support the Provider's position. He also acknowledged that the Intermediary indicated that a sampling might be sufficient. However, when the Intermediary did not get back to him to specify records for a sampling, the Provider did not furnish any documentation whatsoever of utilization review records to the Intermediary<sup>7</sup> nor did the Provider furnish any support to the Board for its position. We also note the Provider witness' correspondence to the Intermediary in which he stated that "[u]nfortunately, I must admit that some of the facilities do not keep complete records of UR meetings."<sup>8</sup>

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<sup>4</sup> Tr. at 133.

<sup>5</sup> Tr. at 37:18

<sup>6</sup> Tr. at 145:10-146:20.

<sup>7</sup> Tr. at 150:1-154:1.

<sup>8</sup> Tr. at 155:24-156:9.

Because the Provider failed to furnish relevant records to support its position, the Board concludes that the Intermediary's adjustment was proper.

Based on the evidence submitted and the above mentioned testimony, the Board concludes that the Provider did not furnish sufficient documentation to prove its position.

DECISION AND ORDER;

The Intermediary's adjustment of the Provider's Medical Director's UR cost was proper, due to a lack of documentation. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esquire  
Henry C. Wessman, Esquire  
Gary D. Blodgett, DDS  
Martin W. Hoover, Jr., Esquire.

DATE: August 28, 2003

FOR THE BOARD:

Suzanne Cochran  
Chairman