

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2004-D45

PROVIDER –
Florida Convalescent Centers Group
Appeals

Provider No. Various

vs.

INTERMEDIARY –
First Coast Service Options, Inc./
Blue Cross Blue Shield Association

DATE OF HEARING –
September 5, 2003

Cost Reporting Period Ended
December 31, 1997

CASE NO. 00-2151G

INDEX

	Page No.
Issue.....	2
Statement of the Case and Procedural History.....	2
Parties' Contentions.....	3
Findings of Fact, Conclusions of Law and Discussion.....	4
Decision and Order.....	4

ISSUES:

1. Whether the Intermediary's disallowance of the Provider's therapy management fees was proper?
2. If the Providers are found to be entitled to a reversal of the Intermediary's disallowance, does the Board have subject matter jurisdiction to determine what entity is entitled to payment?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This is a dispute over Medicare payment for services to Medicare beneficiaries. During the time period at issue, Florida Convalescent Centers (FCC or Provider) operated skilled nursing facilities (SNFs) throughout the State of Florida, including the twelve Providers in this case.

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the Providers under the Medicare law and under interpretative guidelines published by the Centers for Medicare and Medicare Services (CMS).

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 what proportion of those costs are 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 publishes it in a notice of program reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Providers contracted with a rehabilitation management firm to provide a comprehensive system to integrate and coordinate rehabilitative services rendered by the Providers' physical (PT), occupational (OT) and speech (ST) therapy departments. Each Provider paid a flat monthly fee of \$10,000 per month (or \$120,000 per year) for these services. The Providers included the therapy management fees in the therapy ancillary cost centers on their cost reports asserting that these services benefited only the therapy departments rather than the institution as a whole.

First Coast Service Options, Inc. (Intermediary) reclassified a portion of the fees (\$20,000 per Provider) to the Administrative and General (A&G) cost center, which had the effect of lowering the portion of the fees apportioned to Medicare. In addition, the Intermediary disallowed \$50,000 per Provider on the grounds that the fees were excessive (\$25,000) and partially attributable to marketing services (\$25,000). In this group appeal, the Providers challenged approximately \$601,079 in cost adjustments and met jurisdictional requirements for Board review.

While the appeal to the Board was pending, the Providers and the Intermediary reached an administrative resolution in which the Intermediary agreed to reverse the disallowances under

appeal. The administrative resolution was memorialized in a Settlement Agreement signed by the Intermediary on March 21, 2002, and on June 6, 2002, the Board granted the Providers' request to withdraw this appeal pending fulfillment of the settlement and closed the appeal.

Prior to the Intermediary's therapy cost adjustments, FCC entered into a lease agreement with Integrated Health Services (IHS) by which IHS would lease and operate twelve of the Providers' skilled nursing facilities. The leased facilities are those for which the Providers challenge the Intermediary's FY 1997 adjustments.

On February 2, 2000, IHS filed for Chapter 11 bankruptcy. In re Integrated Health Servs., Inc., 289 B.R. 32, 34 (Bankr. D. Del. 2003). Although the details of the bankruptcy proceedings are not entirely clear, those details are not dispositive of the issues before the Board. It is undisputed that agreements were reached in the bankruptcy proceeding between IHS, CMS and others concerning transfer of various facilities, including the transfer of the Medicare provider agreements. Although the Intermediary disputes FCC's role in the bankruptcy,¹ FCC claims that it was not a party to the bankruptcy or to the agreement reached in that proceeding. Regardless of FCC's role, if any, as a result of the transfers of Provider agreements, the Intermediary did not pay FCC the amounts covered by the settlement agreement with FCC. Instead, the Intermediary applied those payments to amounts owed to Medicare by FCC's successors to the provider agreements. After FCC did not receive payment under the settlement agreement, it petitioned the Board for reinstatement of its case, as provided under the Board's procedural rules.

The Provider was represented at the hearing by Julie A. Bowman, Esq., of Copeland, Cook, Taylor and Bush, P.A. The Intermediary was not present or represented at the hearing.

PARTIES' CONTENTIONS:

The Intermediary stipulated that the disallowances made to the Providers' therapy management costs were improper and should be reversed but it asserts that it has fully complied with the settlement agreement. It argues that the provider agreements that are preconditions to Medicare payment were transferred, and thus the Intermediary has no authority to pay FCC. It points out that under Medicare law and policy, obligations to and from the Medicare Program follow the provider agreement; consequently, it can only pay the holder of the provider agreement. It asserts that FCC's claim for those funds arises from FCC's and IHS's contractual agreement. Thus, FCC's dispute as to receipt of payment is with IHS, not the Intermediary.

The Intermediary argues further that FCC lost its standing as a provider and is, therefore, not even properly before the Board in this reinstated proceeding. Moreover, the Board has no subject matter jurisdiction over disputes between providers as to which is entitled to payment.

The Providers respond that they were not parties to the transactions and agreements reached in the bankruptcy; therefore, those agreements cannot be used to deprive FCC of its ability to receive payments under the settlement agreement. It insists that the Board has the power to

¹ See Intermediary's September 2, 2003 letter to the Board addressing the jurisdictional issues. The Intermediary points out that as part of the documentation for the Stipulation and Bankruptcy Order, there was a release of all prior lease obligations between tenant IHS and its landlord, identified as Palm Gardens Healthcare, not FCC.

determine which entity is the proper payee under Medicare law and to order the Intermediary to make payment to FCC. It relies on several prior Board decisions in which the Board has reversed intermediary adjustments and ordered reimbursement to the provider. The Providers also rely on the Administrator's reversal of a Board decision that the intermediary had improperly disallowed a carry forward of the lower of cost or charges (LCC) generated under prior ownership.²

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, evidence presented and parties' arguments, the Board finds and concludes that the Intermediary's adjustments should be reversed; however, the Board does not have subject matter jurisdiction to determine what entity is entitled to be paid as the provider.

The Intermediary conceded that the adjustments to the Providers' therapy costs were in error, and the Board has no reason to question that representation. Although the Intermediary's failure to argue in the adjustments' favor does not require us to accept the Providers' arguments, we find that the therapy management costs are allowable.

The Board was established to hear disputes "with respect to [a] cost report" if a provider is dissatisfied "as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title . . ." 42 U.S.C. §1395oo(a)(1) (emphasis added). The Board has the power to affirm, modify or reverse an intermediary's final determination "with respect to a cost report . . ." Given the Intermediary's stipulation, the amount of reimbursement is not in dispute. The only issue remaining is whether the Providers who brought the appeal or successors to the Medicare provider agreements should be paid under the settlement agreement. These are contract disputes outside the limited jurisdiction of the Board.

The Providers' reliance on prior Board decisions in which the Board reversed intermediary adjustments and ordered payment is misplaced. Simply ordering payment in connection with a reversal does not resolve which entity is the "provider" for payment purposes if there is a dispute. Likewise, the Administrator's reversal in North Florida does not support the Providers' position. That case involved a reimbursement principle that specifically addressed the LCC carry forward to subsequent years and specifically addressed the circumstances under which a successor could claim the benefit of the carry forward. The application to other years and entities was, therefore, an integral part of the reimbursement determination itself. There is no similar principal involved here. The reimbursement amount, the only matter over which the Board has been given authority, is no longer in dispute.

DECISION AND ORDER:

The Intermediary's adjustment to therapy management costs were improper and are reversed.

² N. Fla. Physical Therapy Servs. V. Aetna Life Ins. Co., HCFA Admin. Dec. (Feb. 3, 1998), CCH MED-GUIDE ¶46, 138, rev'g PRRB Dec. No. 98-D10 (Dec. 5, 1997), CCH MED-GUIDE ¶45,908. (North Florida)

The Board lacks jurisdiction of whether the Providers or their successor entities should be paid under a settlement agreement reversing the Intermediary's disallowances.

Review of this determination is available under provisions of 42 U.S.C. §1395oo(f)(1) and 42 C.F.R. §§505.1875 and 405.1877.

BOARD MEMEBERS PARTICIPATING:

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FOR THE BOARD:

DATE: September 30, 2004

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