PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D62

PROVIDER -
Shady Lawn Nursing Home
Vicksburg, Mississippi

Provider No.: 25-5234

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TriSpan Health Services

DATE OF HEARING -
June 22, 2005

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 01-0077

INDEX

ISSUE:

Whether the Intermediary's adjustment removing the Provider's "grossing up" of costs and charges for drugs charged to patients was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due to a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 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 NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

The Medicare cost report uses a process known as "cost finding" to determine the amount of program reimbursement due a provider. Cost finding recognizes that the costs accumulated in non-revenue producing departments within a provider's accounting system, such as depreciation and administrative and general expenses, contribute indirectly to producing revenue. Therefore, to match costs with revenues, cost finding uses methods of allocating the costs of the non-revenue producing centers to the revenue producing centers using different bases such as square feet for depreciation. Once all costs have been grouped in the revenue producing costs centers, they can be apportioned to Medicare based upon utilization, e.g., the ratio of Medicare charges to total charges applicable to each respective cost center.

In some instances, providers furnish ancillary services to Medicare patients under arrangements with others. The provider pays the supplier and requests reimbursement from the Medicare program. However, in other instances, a provider may arrange for such services for non-Medicare patients and make no payments, e.g., Medicaid programs may pay suppliers directly. In these instances, the provider's records will reflect only the cost of services to Medicare patients. Therefore, the allocation of indirect costs to a cost

center that includes only the cost of Medicare services would result in excessive assignment of indirect costs to the program; since services were also arranged for non-Medicare patients, part of the overhead costs should also be allocated to that group of patient services.

Where a provider arranges for services for non-Medicare patients and does not pay the vendor for them, it is impossible for the provider to allocate indirect costs to that cost center unless it can "gross up" the costs and charges for the non-Medicare patients. According to Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §2314.B, "gross up" of costs means applying to the non-Medicare patient services the same schedule of charges used by the servicing entity when billing the provider for Medicare patient services. These costs are added to the costs of services for the Medicare patients. "Grossing up" of charges means applying the provider's standard charge structure to the non-Medicare patient services. These charges are added to the charges for services for Medicare patients and used to apportion costs to the Medicare program.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Shady Lawn Nursing Home (Provider) is a skilled nursing facility (SNF) located in Vicksburg, Mississippi. During its cost reporting period ended December 31, 1998, the Provider operated under a state Medicaid plan that did not allow SNFs to bill the Medicaid program for drugs charged to Medicaid recipients. Therefore, the Provider's accounting system did not collect cost and billing data for Medicaid patients receiving drugs. However, in order to allocate overhead expenses to the "drugs charged to patients" cost center, the Provider filed its cost report using the "gross up" method of cost finding. TriSpan Health Services (Intermediary) reviewed the Provider's cost report and made an adjustment disallowing the Provider's use of the gross up methodology. The Intermediary found that the Provider had not obtained prior approval to use the grossing up methodology, and that the Provider's records were insufficient to verify the Medicaid cost and charge data used to prepare the cost report.

The Provider appealed the Intermediary's adjustment to the 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 $5,000.[1]

The Provider was represented by William A. Grimes of Reingruber & Associates, Inc. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and regulations, parties' contentions, and evidence presented, finds and concludes as follows:

[1] The Provider's appeal to the Board contained an additional issue with a Medicare reimbursement effect of approximately $11,000. Although this issue was subsequently withdrawn, it allowed the Provider to meet the minimum amount in controversy requirement of $10,000 to qualify for a Board hearing.

The Intermediary disallowed the Provider's use of the grossing up method of cost finding for the cost of drugs charged to patients. As discussed immediately above, the Intermediary argues that the Provider should not be allowed to use the grossing up methodology because it had not received prior approval to do so, and because the Provider's records were insufficient to support Medicaid cost and charge data needed to prepare its cost report. The Board, however, disagrees with the Intermediary and finds that the Provider's use of the grossing up methodology was proper.

Program instructions contained at HCFA Pub.15-1 §2314.B require providers to receive written approval from their intermediary before using the grossing up methodology. However, the Board has consistently held that a provider's use of the grossing up methodology, even without prior approval, is consistent with 42 U.S.C. 1395x(v)(1)(A), which directs the program to reimburse providers the reasonable costs they incur to furnish services to Medicare beneficiaries.[2] The grossing up methodology clearly results in a more accurate determination of Medicare reimbursement than not allowing an allocation of overhead to a cost center, which is the alternative if use of the grossing up methodology were denied. The Board notes that a letter written by CMS dated March 31, 1995, which is referenced in Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D13, Dec, 1996, Medicare & Medicaid Guide (CCH) ¶44,923, Dec. Rev. HCFA Administrator, January 14, 1997 (Sunbelt) reinforces its position. In part, the letter states:[3]

> [t]he provider ignored a threshold requirement . . . by failing to obtain approval from the fiscal intermediary to use the direct assignment of costs. While we believe this is an important requirement that should not be ignored by providers, our enforcement of this requirement has been reshaped by practical considerations. We have never been sustained on appeal in situations where failure to obtain prior approval is the only defect in a providers use of a cost allocation alternative. The PRRB has adopted a "no harm, no foul" approach to enforcing this requirement. That is, as long as the provider's cost allocation alternative produces a more appropriate and more accurate allocation of cost, and is supported by adequate, auditable documentation, the provider's alternative has been accepted. . . .

In rejecting the Intermediary's arguments, the Board also finds that the documentation used by the Provider to gross up its Medicaid costs and charges, as well as the methodology used to do so, is appropriate. The Provider obtained the actual charges billed by its supplying pharmacy to the Medicaid program for the Provider's patients.

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[2] See also. , Florida Life Care, Inc. Group –"Gross-Up" v. Aetna Life Insurance Company , PRRB Dec. No. 90-D25, May 9, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,522, Dec. Rev., HCFA Administrator, June 14, 1990.

[3] See Sunbelt at Exhibit P-9.

The Provider grossed up its drug costs by adding these charges to the actual drug costs it incurred for its Medicare and other patients. Next, the Provider grossed up its drug charges by applying the ratio of its cost to charges for its Medicare and other patients to the pharmacy's Medicaid charges and adding the result to its Medicare and other patient charges.[4] This process yielded an overall cost to charge ratio of .585646.[5]

The Board finds that the pharmacy data used by the Provider was likely the best data available for the Provider to use to gross up its costs and charges. This data produced a reasonable cost to charge ratio that is likely a conservative result since pharmacies may bill nursing homes and other providers more than they bill Medicaid. Moreover, the Board is unaware of any other methodology the Provider may have used to gross up its costs and charges for drugs charged to patients, and the Intermediary did not, in the instant case, specify any other methodology that may have been more appropriate.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's use of the grossing up method of cost finding for drugs charged to patients was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West

Date of Decision: April 4, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

[4] Exhibits P-7 and P-8.

[5] Exhibit P-5 at Worksheet C.