CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Logos Health Care Rehabilitation, Inc., **Provider** **vs.** **Blue Cross/Blue Shield Association Palmetto Government Benefits Administrators** **Intermediary**	**Determination of reimbursable Costs for Cost Reporting Period Ending:** **12/31/93** **Review of:** **PRRB Decision 2006-D42** **Dated: August 4, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Comments were received from the CMS' Center for Medicare Management (CMM) requesting reversal of the Board's decision on Issue No. 16. The parties were notified of the Administrator's intention to review the Board's decision regarding Issue No 16. The Provider requested affirmation of the Board's decision on Issue No. 16. Accordingly, this case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment to accounting expense was proper.[1] The Board reversed the Intermediary's adjustment to accounting expenses, finding that all accounting costs should be allowed based on the percentage of allowable accounting invoices submitted by the Provider. The Board noted that the Provider submitted transaction invoices covering 50.52 percent of its total accounting costs. The Board concluded that the Intermediary's requirement of

[1] The case involved 21 other issues and one withdrawn issue. The Administrator summarily affirms the Board on these remaining issues.

submission of 100 percent of invoices was not reasonable and that no disallowance for accounting expense should be made.

COMMENTS

CMM requested reversal of the Board's decision, stating that the Intermediary was correct in disallowing costs that were not substantiated. The Intermediary initially disallowed the Provider's claimed accounting expenses, based on insufficient documentation. After further review of the Provider's additional documentation, the Intermediary did not allow any additional costs as the documentation that was furnished could not be traced to the general ledger. Items on the general ledger are essential for Medicare auditors to verify a provider's incurred costs. The Provider argued that it submitted 50.52 percent of its invoices and that said percentage should be sufficient; however, in certain circumstances, it is reasonable for intermediaries to request up to 100 percent of invoices and other documentation when there is concern about the fidelity of the costs or its omissions from the general ledger. CMM stated that it expects intermediaries to audit a sufficient amount of documentation until it is satisfied that a provider actually incurred costs. The Board exceeded its authority in proscribing the type and amount of data that the intermediary can request to verify costs reported by the Provider on its cost report. CMM stated that the Intermediary had requested additional documentation from the Provider after it reviewed the invoices and determined they were not traced to the general ledger. Despite the additional information furnished by the Provider, the Intermediary could not trace additional costs claimed by the Provider on the invoices to the general ledger.

The Provider commented, requesting affirmation of the Board's decision without additional argument.

DISCUSSION AND EVALUATION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Since its inception in 1966, Medicare's reimbursement of health care providers has been governed by §1861(v)(1)(A) of the Act, which provides that:

> Reasonable cost shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services….

With respect to payments, section 1815 of the Act states that:

> [N]o 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.

Further, section 1816(a) of the Act states that the Secretary has delegated to the fiscal intermediary the responsibility of determining the amount of any such payments due a provider under the Program. Thus, as reflected in the statutory language, a provider must submit the documentation necessary to satisfy the intermediary as to the amount due for services rendered under the program.

Consistent with the Act, the Secretary has promulgated regulations at 42 CFR 413.9, which requires that all payments to providers of services must be based on reasonable costs of services covered under Title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing services. In addition, regulation, at 42 CFR 413.20, provides the requirement for financial data and states that:

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payment under the program….

Further, the regulation at 42 CFR 413.24, states that:

> Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This data must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on approved method of cost finding and on the accrual basis of accounting…

Moreover, the above principles are set forth in the Provider Reimbursement Manual or PRM, which provides policies to implement Medicare regulations for determining the reasonable cost of provider services. The PRM provides further guidance on the payment of provider costs. The PRM at §2300 states that providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. Further, the PRM at §2304 states that cost information must be current, accurate, and in sufficient detail to support costs claimed by providers in

rendering services to beneficiaries. Documentation to substantiate costs is to include, among others things, ledgers, books, records and original evidences of cost.

In this case, the record reflects that the Provider claimed certain accounting expenses. The Intermediary allowed those costs that the Provider was able to present adequate, verifiable documentation. However, the Administrator finds that the Intermediary properly denied those costs for which the Provider was not able to present adequate, verifiable documentation.[2] The Administrator finds that the Intermediary's adjustments were in accordance with the statutory and regulatory mandate that provider's receiving payment on the basis of reimbursable cost must provide adequate cost data capable of verification.

DECISION

The Administrator reverses the Board's decision in this case on Issue No. 16 consistent with the foregoing opinion. In addition, the Administrator summarily affirms the Board's decision on the remaining issues.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10/3/06

/s/
Leslie V. Norwalk, Esq.
DeputyAdministrator
Centers for Medicare & Medicaid Services

[2] See Intermediary's Position Paper, Exhibit I-6, pages 10-11. (For example, the audit papers show that where invoices could be traced to the Provider's General Ledger the costs were allowed and to the extent the invoices could not be traced to the General Ledger, the costs were not allowed. The Administrator finds that the Provider also failed to demonstrate that the portion of its claimed accounting cost alleged to be related to an embezzlement investigation was a necessary and proper cost and related to patient care.