CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Mark Reed Hospital **Provider** **vs.** **Blue Cross/Blue Shield Association** **Noridian Administrative Service** **Intermediary**	**Provider Reimbursement for** **Cost Reporting Period Ending:** **12/31/2001** **Review of:** **PRRB Decision 2006-D52** **Dated: September 14, 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)). The parties were notified of the Administrator's intention to review the Board's decision as to Issue No. 1. Comments were received from the Providers and CMS' Center for Medicare Management (CMM). Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION[1]

Issue No. 1, which is before the Administrator, is whether the Intermediary's adjustment to direct nursing costs was proper.

[1] Issue No. 2 of the Board's decision involves whether the Intermediary properly increased the total patient days to include respite care. The Board, affirming the Intermediary's adjustment, found no legal authority to permit carving out the respite care costs or to alternatively treat such costs as unallowable. The Administrator hereby summarily affirms the Board's decision with respect to Issue No. 2.

With respect to Issue No. 1, the Board, modifying the Intermediary's adjustment, held that the stand-by time in dispute should be equally and exclusively allocated between the Adults and Pediatric (acute) (A&P) and emergency room (ER) cost centers in accordance with the Board's methodology. The Board noted that no contemporaneous records existed to accurately differentiate and quantify either the nurses' actual ER time for January and February 2001, or the nurses' actual A&P time for March through December 2001. However, the Board found that time records existed and tabulations were computed for January, February, and March and July 2001.

Accordingly, the Board instructed the Intermediary to determine the actual ER time, for January and February 2001 by annualizing the March and July actual ER time and to apply a prorated monthly figure to those months for which time records do not exist. The Board, likewise, instructed the Intermediary to determine the average monthly A&P time by using the actual A&P time for March through December and applying it to March through December. The Board further instructed the Intermediary to annualize the data from January, February, March and July and to apply a prorated monthly figure to those months for which time records do not exist for the other cost centers. Finally, the Board directed that, once the actual times are quantified, the remaining claimed time, which represented stand-by time, should be allocated equally and exclusively between A&P and ER.

SUMMARY OF COMMENTS[2]

The Provider commented, requesting affirmation of the Board's decision. The Provider asserted that the Board's decision is not ambiguous. The Provider maintained that the PRRB instructed the Provider to track the direct cost associated with acute care and emergency room cost centers and allocate equally and exclusively between these cost centers any additional cost associated with stand-by costs. Citing to the record, the Provider argued that the Board's determination represents a fair and rational allocation basis between ER and acute. This solution

[2] The Intermediary commented, requesting modification or clarification of the Board's decision. The Provider raised an issue as to the timeliness of the Intermediary's comments. Pursuant to the regulation, at 42 CFR 405.1875(b), a request for Administrator's review must be filed within 15 days of the receipt of the Board decision. In this case, the certified mail receipt reflects that the Intermediary received the Board's decision on September 19, 2006. Thus, the Intermediary's request for review must be filed by October 4, 2006. In this case, however, the Intermediary's request was not filed until October 5, 2006. Accordingly, as the comments were not timely, the comments have not been considered by the Administrator during this review.

requires stand-by costs to be allocated equally between the two predominant departments: acute care which is required to be staffed at all times by State regulation and ER which is required to be staffed on an available basis by State and Federal regulations.

CMM commented, requesting reversal of the Board's decision. CMM pointed out that the statute and regulations require providers to maintain sufficient financial records and adequate statistical data for proper determination of costs under the Program. In this case, the Provider failed to do so.

CMM noted the Provider's instruction to its nursing staff that all time not specifically allocated to a department would be reported in the acute care department. Regarding such allocation of time, CMM stated that it is not based on specific Medicare regulation or guideline, but rather was intended to secure a certain level of reimbursement. The Provider's change in time reporting results in an inappropriate shifting of the costs of nursing services to the A&P cost center. CMM pointed to the Intermediary's statement that there were no material changes regarding the patients' use of services or staffing duties accompanied by the shift in nursing costs to the A&P cost, but there was a significant increase in Medicare reimbursement. However, CMM argued that a provider's costs, including the cost of nursing services, are to be included in the cost centers where the services are performed.

Further, CMM argued that the Board's recognition of the lack of records to accurately differentiate and quantify nurses' time could have resulted in a disallowance of all costs for time not supported by appropriate documentation. However, although recognizing the lack of proper documentation, the Intermediary made a reasonable effort to identify actual nursing hours in the various department in which the nurses worked and to proportionally allocate nurse stand-by time to those departments. CMM noted that the Board's methodology is not more accurate than the Intermediary's adjustment. In fact, the Board's approach which allocates all stand-by time equally between A&P and ER does not match the nursing time actually worked in the various departments. Thus, CMM concluded that the Board erred in finding that the stand-by time should be equally allocated between the A&P and ER cost centers.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been included in the record and 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 and shall be determined in accordance with regulations establishing the method or methods to be used …
>
> Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs …

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, the 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.

In this case, the Provider is a certified critical care hospital (CAH), reimbursed based on reasonable costs. As noted above, the Provider must maintain and provide adequate cost data to support its claimed costs and accurately allocate costs to the Medicare program. The Administrator finds that the Provider failed to maintain and provide such data to support its claimed costs.

The record reflects that there was a significant increase in costs for the general routine cost center (A&P) and per diem cost for the cost year at issue.[3] On audit, the Intermediary determined that this increase was directly related to a change in the method of allocating nurses' time on time sheets,[4] and resulted in a significant

[3] See Intermediary Exhibit I-1 pp. 1-3. The Intermediary noted that the Provider's routine costs increased 731 percent from the previous year. In addition, the Provider's per diem increased from $1,505 for the previous year to $7,405 for the year at issue. Conversely, the related charges actually decreased slightly from the prior year.

[4] See Intermediary Exhibit I-1, p. 7. The memorandum from the Provider's Assistant Administrator instructs nursing staff to change how time is allocated. The memorandum states, in part:

portion of time being incorrectly allocated to A&P as standby time.[5] Thus, the Intermediary adjusted the Provider's cost report accordingly.[6]

The Administrator notes that the Provider apparently changed its method of allocating nurses time shortly after being certified as a CAH in order to maximize its costs. Under the Provider's method, time recorded in A&P represented all time remaining after the nursing staff recorded direct patient care time for other departments, as well as the ER. However, the Administrator finds that this change resulted in a significant portion of time being allocated to A&P as standby time without any documentation to support this allocation. The Provider maintained only a few months of time sheets but claimed that its method of maintaining time was consistent with State and Federal requirements. The Administrator finds that the Provider's method of recording and allocating nursing services to the A&P after its certification as a CAH, does not result in proper, accurate cost finding and, thus, is not support by Medicare law, regulations or policy guidelines.

In this instance, the Administrator finds the Intermediary, although recognizing the lack of proper documentation, used a reasonable methodology to identify direct nursing hours in the various departments and proportionally allocated nursing standby time to those departments. The Administrator also finds that, although the Board acknowledged that the Provider's documentation was lacking, the Board's proposed methodology for allocating costs does not represent a more accurate

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> "Previously you had been directed to allocate the majority of your time to the ER. This is no longer the case, and this change is very important to our reimbursement. You are to allocate to ER only time that you are actually taking care of an ER patient (same for AHC, Dietary, etc.) All time that is not specifically allocated to another department now goes to acute care which is considered by Medicare to be your 'home' department…."

[5] See Intermediary's Position Paper, p. 3. The Intermediary noted that, under the new instruction, time recorded in the A&P was the time remaining after the nursing staff recorded their actual patient care time for the other departments, including ER.

[6] The Intermediary found that there were no time records for actual time spent in the A&P cost center for three quarters of the fiscal year at issue. Thus, the Intermediary reasonably allowed 24 hours of nursing care for every patient day as direct patient care time for the A&P cost center. Using that figure, and the time records for the other departments, the Intermediary allocated the standby time based on a ratio of the direct time to all of the areas where the nursing staff worked. See Intermediary Exhibit I-2.

method of cost finding. For example, the Board's approach results in standby costs being allocated to the A&P cost center disproportionate to the direct nursing time identified for that department. Thus, the Board's methodology results in inappropriate cost shifting.

Applying the above law to the facts in this case, the Administrator finds that the Provider failed to maintain and submitted adequate time records to support its allocation of costs. The Intermediary's adjustment is in accordance with the statutory and regulatory mandate regarding proper payments to providers on the basis of reimbursable cost. Accordingly, the Board's decision is reversed as to Issue No. 1.

DECISION

The decision of the Board is reversed as to Issue No. 1 in accordance with the foregoing opinion. The Intermediary's adjustment as to Issue No. 1 is affirmed. The decision of the Board is summarily affirmed as to Issue No. 2.

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

Date: 11/9/06

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