PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D62

PROVIDER -Elzora Manor

Provider No. 38-5161

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Oregon

DATE OF HEARING-
June 9, 1999

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 96-0122

INDEX

ISSUE:

Was the Intermediary's adjustment limiting contracted occupational therapy and speech therapy costs to $104 per hour proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Elzora Manor ("Provider") is a 129 bed for-profit skilled nursing facility (SNF) located in Milton-Freewater, Oregon. The Provider is located in rural Oregon. The Provider elected the SNF Prospective Payment System ("PPS") method of reimbursement for the year under appeal.[1] During the FYE December 31, 1993, the Provider purchased occupational therapy ("OT") and speech therapy ("ST") services from Sundance Rehabilitation Corporation ("Sundance"), an entity not related to the Provider. Under the terms of the contract with Sundance, the Provider was charged $30 per fifteen minute increment of service or $120 per hour.[2]

In its 12/31/93 Medicare cost report, the Provider claimed cost of $64,200 for OT services and $55,390 for ST services. This represented the actual amount the Provider paid to Sundance for therapy services rendered to the Provider's patients.

Blue Cross and Blue Shield of Oregon ("Intermediary") contends it was notified by HCFA to review for occurrences where providers were paying excessive amounts for contracted occupational therapy and speech therapy services. Therefore, the Intermediary conducted a survey of its providers to determine the "going price" being charged for contracted OT and ST services.[3] From its survey, the Intermediary determined that the "going price" was $104 per hour for occupational and speech therapy services contracted under arrangement in skilled nursing facilities. Since the Provider was paying $120 per hour for its therapy services, the Intermediary contends it asked the Provider if it had done any competitive bidding. When the Provider stated that there were no competitive bids, the Intermediary asked for justification for the $120 per hour amount. The Intermediary contends that when it did not receive "clear justification" for the $120 per hour amount paid by the Provider, it applied the $104 per hour as the "going price" under Provider Reimbursement Manual, Part 1 (HCFA Pub.15-1), § 2103, the prudent buyer principle.

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[1] Intermediary Position Paper at 1.

[2] Intermediary Exhibit I-2, Exhibit B.

[3] Intermediary Exhibit I-1.

The Intermediary issued a Notice of Program Reimbursement (NPR) on May 24, 1995 that included this reduction in cost.[4] The Provider timely appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.[5] The approximate amount of Medicare reimbursement in controversy is $16,702.[6]

The Provider is represented by Donna K. Thiel, Esquire, of Gardner, Carton & Douglas. The Intermediary is represented by Bernard Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the issue the Board must decide in this case is whether, in the absence of Program law, regulation, and instructions, the Intermediary can retroactively impose its own artificially created limits on the cost of contracted OT and ST services. The Provider refers to 42 C.F.R. § 413.9 which discusses the conditions under which providers will be paid for the cost of covered services rendered to Medicare beneficiaries.

It is the Provider's position that the regulation quoted above makes it crystal clear that providers are to be paid the reasonable cost of covered services rendered to Medicare beneficiaries. The Provider asserts that the only limitation placed upon cost by the regulation is when a provider's cost is determined to be "substantially out of line with the cost of other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." 42 C.F.R. § 413.9 (c)(2). The Provider contends there is nothing in the regulations that provides for the retroactive imposition of unpublished cost limits on a provider's cost.

On the contrary, the Provider asserts that the regulation requires that reimbursement for services to Medicare beneficiaries be "determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 C.F.R. §413.9 (b)(1). The Provider contends that absent specific regulatory mandates regarding how a particular item of cost is to be reimbursed, the reasonable cost principle must be applied.

The Provider contends that intermediaries do not have the authority to establish cost limits and apply them to Medicare providers as they see fit. The Provider asserts that Congress has delegated to the Secretary of Health and Human Services the authority to promulgate Medicare regulations, including cost limits when necessary. To date, however, the Provider notes that the Secretary has not

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[4] Provider Exhibit P-1.

[5] Provider Exhibit P-2.

[6] Provider Position Paper at 2. Intermediary Position Paper at 2 indicates the reimbursement effect is $16,085.

undertaken the procedures prescribed by regulation to establish limits on the reimbursement of OT and ST services. The Provider contends that until the Secretary publishes cost limits, it is unlawful to apply limits to these costs.

The Provider contends that its decision to contract for OT and ST services was based on a number of factors, and was both prudent and reasonable within the clear meaning of the regulation. In support of its decision to contract for OT and ST services, the Provider refers to a letter dated May 10, 1995 in which the Provider's Administrator sets forth the rationale used in choosing Sundance to provide OT and ST services to its residents.[7] The Provider contends that it is evident from this letter that the level of service it had been receiving from the therapists employed by another provider was sporadic, unreliable, and failed to meet the on-going needs of its patients.

The Provider points out that in the previously mentioned letter, the Administrator also considered the option of hiring in-house therapists. The Administrator concluded that its facility lacked the expertise needed to pursue this alternative. The Provider points out that while the possibility of hiring in-house therapy staff may be a viable option for some facilities, those located in rural areas often find it difficult to hire qualified therapists to staff each of the therapy specialties. Furthermore, the Provider contends that it is both costly and difficult to establish an in-house therapy department with effective supervision and adequate record keeping.

The Provider contends that 90% of the SNFs across the country contract for their OT and ST therapy needs. The Provider also points out that the Intermediary's own survey results revealed that 100% of the providers that offered OT and ST services contracted for the provision of the services.[8] Therefore, the Provider contends that based on its Administrator's point of view, the facility acted prudently when it decided to contract for its therapy service needs.

The Provider rejects the Intermediary's assertion that it should have obtained competitive bids before entering into the contract with Sundance. The Provider contends that there is no statutory or regulatory requirement that contracts for services be competitively bid, nor is there a law that sets limits on the reimbursable cost of OT and ST services. Rather, the Provider asserts that the Medicare program relies upon the principle of reasonable cost enunciated in 42 C.F.R. § 413.9 and on the Program instructions contained in HCFA Pub. 15-1 § 2103, the prudent buyer concept. This instruction states in part:

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[7] Provider Exhibit P-3.

[8] Intermediary Exhibit I-1, page 6.

> A. General.-- The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he also seeks to economize by minimizing cost.

HCFA Pub. 15-1 § 2103.

The Provider contends that in evaluating reasonable cost under the prudent buyer principle, an intermediary's evaluation cannot be based on an arbitrary determination. The intermediary must use an appropriate methodology for determining that payments for services exceed the level paid by comparable providers. The Provider further contends that in making this decision, the intermediary is required to perform and document a verifiable analysis in establishing the "going rates" within local markets for similar services.

The Provider notes that in addressing the prudent buyer standard, Section 2130.1 of the Medicare Intermediary Manual (HCFA Pub. 13-2) provides:

> The application of this concept by intermediaries does not envision that intermediaries will spend audit funds routinely in attempts to locate situations where a provider may have failed to act prudently in one or more aspects of its business operations or transactions. Rather, it intends that intermediaries be alert, from their professional contacts with providers and their cost report settlement process, to situations where a provider's cost of operations will become or in fact already are out of line (i.e., appear unreasonable with similar cost of comparable providers.)

HCFA Pub. 13-2 § 2130.1

Thus, the Provider asserts that the Intermediary must first do the necessary analysis in comparing costs of similarly situated providers before it can embark on a provider-specific review. The Provider argues that the mere fact that its costs vary from those of another provider should not subject it to routine, individual scrutiny, nor should it serve as the basis to challenge reimbursement. The Provider contends that its claimed costs should be presumed "reasonable" until the Intermediary is able to present evidence to the contrary, and only after the Intermediary has appropriately determined that the Provider is paying an amount for a service that is substantially out of line does the burden of proof regarding prudency shift to the Provider.

The Provider rejects the Intermediary’s contention that it has met its burden of proof of demonstrating that the Provider was paying more than the going price for its occupational and speech therapy. The

Provider challenges the results of the survey for several reasons [9]. Following is a summary of the Provider's reasons it believes the survey is flawed:

1. The survey was not statistically valid. The Provider contends there was no evidence that the Intermediary used statistically valid methodology.

2. The survey was based only on the location of the facility. The survey failed to include factors such as size, scope of services, utilization, and patient acuity.

3. The survey results were not uniformly applied to all providers serviced by the Intermediary. Certain providers were singled out for application of the survey results.

4. It appears that providers were not required to complete the survey. The Provider contends that of the 70 providers surveyed, 12 (over 17%) either failed to respond to the survey, or did not provide any therapy services at all. The Provider further contends that the Intermediary has provided no details concerning whether the unresponsive providers were contacted; nor has it addressed this significant rate of unresponsiveness.

5. Only the providers serviced by Medicare Northwest were included in the survey. It is the Provider's position that the size of the survey (70 providers in 3 states), coupled with the small number of responding providers (58), raises questions about the reliability of the survey's results.

6. The results of the survey were retroactively applied. The Provider contends that the survey was completed in late 1994 or early 1995 and that the results were retroactively applied to the Provider's 12/31/93 cost reporting period. The Provider contends that even if the Intermediary had the authority to establish cost limits, any such limits would be required to be applied on a prospective basis. The Provider argues that the Intermediary is attempting to implement retroactive cost limits, however, it is expressly forbidden from doing so by the Supreme Court's decision in Bowen v. Georgetown University, 488 U.S. 204 (1988) ("Georgetown")[10]. In Georgetown, the Court concluded that: "Our interpretation of the Medicare Act compels the conclusion that the Secretary has no authority to promulgate retroactive cost-limit rules." [11] The Provider maintains that if the Secretary is forbidden to promulgate retroactive cost limit rules, any attempt by a fiscal intermediary to do so under the guise of a "prudent buyer" analysis must be thwarted.

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[9] See Provider Position Paper at 9-11.

[10] Provider Exhibit P-5.

[11] Id. at page 6.

The Provider further attacks the Intermediary's survey on the basis that it fails to indicate how the imposed rate of $104 was calculated. The Provider asserts that it is evident from a review of the listing of survey responses that the providers surveyed did not understand the "unit of service" for which they were being asked to provide cost data. The Provider notes that the lowest amount listed for OT or ST services is $16.56, the highest is $150. Based on this, the Provider maintains that the definition of the "unit of service" was not made clear to the providers being surveyed. The Provider maintains that where convenient, the Intermediary simply multiplied the low numbers by 4 to arrive at an "hourly rate." But where large numbers such as $100 or $150 were reported, the Intermediary assumed that the provider had already reported its "hourly rate."

The Provider contends that even if the Board determines that the imposition of retroactive limits on its OT and ST services was proper, the calculation of the reasonable amount allowed per hour is fatally flawed. This assertion is based upon the fact that the Intermediary assumed that four 15-minute modalities of treatment could be performed every hour by every therapist. This assumes a 100% productivity rate for each of the therapists. Consequently, the Provider points out that it fails to take into account the time required for meeting with patients and/or their families, preparing billings, and for performing the record keeping duties essential to the documentation of quality care.[12]

The Provider notes that should the Board wish to analyze the reasonableness of the rate the Provider paid for its OT and ST services, it is reasonable to assume a productivity factor of 3.3 modalities per hour. This would result in an actual productive rate per hour of $99, a rate that is well under the "limit" established by the Intermediary. (3.3/4 = 82.5 x $120 = $99 compared to the $104 limit).

The Provider also notes several Board decisions regarding substantially out of line/ prudent buyer adjustments and attempts by intermediaries to impose limits on providers' costs based on studies that were flawed. Included herein by reference are Board decisions in the following cases: Lakeland Manor Nursing Center (Chicago, IL.) v. Aetna Life Insurance Company, PRRB Dec. No. 91-D34, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶39,153), Heather Manor Nursing Center (Harvey, IL) v. Aetna Life Insurance Company, PRRB Dec. No. 91-D35, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,154), and Oxford Lane, Ltd. (Naperville, IL) v.Aetna Life Insurance Company, PRRB Dec. No. 91 -D36, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,178.

For these reasons, the Provider maintains that the Intermediary has arbitrarily established and retroactively applied salary equivalency-like cost limits to the Provider's OT and ST services when there is no foundation in Program law, regulation, or instructions that permit such an action. Absent a clear demonstration that the Provider's costs are substantially out of line with those of comparable

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[12] See Provider Exhibit P-4.

facilities, the Provider strongly maintains that it has complied with both the reasonable cost principles of the regulations and with the intent of the prudent buyer provisions of the manual.

The Provider maintains that it is clear from a review of the facts in the instant case that the Intermediary abused its discretion when it limited the Provider's reasonable cost of therapy services to artificially set retroactively imposed "limits" that were based on a flawed survey. The Provider maintains that the Intermediary's actions far exceed the authority granted by the reasonable cost provisions of 42 C.F.R §413.9. The Provider respectfully requests that the Board reverse the Intermediary's adjustment and allow the reasonable cost of its therapy services.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it relied on the provisions of 42 C.F.R. § 413.9 and HCFA Pub. 15-1 § 2103 in determining that the contracted costs of the Provider's ST and OT services were excessive. Based on its survey, the Intermediary maintains that it has clearly demonstrated that the Provider was paying in excess of the going price for its OT and ST services. The Intermediary contends that it used the "most prevalent rate" by the "most prevalent provider of service" in a service area. The Intermediary points out that the service areas were classified into, 1) Standard Metropolitan Statistical Areas (SMSA) and, 2) one for all remaining rural providers.

The Intermediary notes that while the results of the survey[13] showed that the "going price" in the rural Oregon service area was $104 per hour; the Provider paid $120 per hour. In retrospect, the Intermediary finds that had it used the results of Umatilla county only, the "going price" would have been $96 per hour of service, rather than the $104 an hour that was allowed.[14]

The Intermediary maintains that it has met its burden of proof, as evidenced by its survey, that the Provider was paying a price for OT and ST services that was substantially out of line with that paid by similar facilities.[15] The Intermediary argues that the burden of proof now shifts to the Provider to submit "clear justification for the premium" it paid as required by HCFA Pub. 15-1 § 2103.

The Intermediary also questions the Provider's incentive for contracting for more costly ancillary services. The Intermediary asserts that when a provider is over the routine cost limits or elects to be paid a set PPS amount for routine services, it has an incentive to incur higher ancillary costs. Increasing the direct costs of an ancillary cost center shifts the allocation of overhead costs from routine services (which would not decrease routine reimbursement) and increases ancillary reimbursement. The

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[13] Intermediary Exhibit I-1.

[14] Intermediary Position Paper at 5.

[15] Intermediary Position Paper at 5.

Intermediary points out that if the Provider had paid $60 per hour instead of $120 per hour, then it would have been reimbursed one half the amount of allocated administrative and general overhead costs by the Medicare program.

The Intermediary notes that the Provider elected the SNF routine PPS payment methodology. The Provider's Medicare utilization for OT and ST services was approximately 90%. Therefore the Intermediary contends there is an incentive by the Provider to incur higher therapy cost because the greater the direct costs means a larger allocation of indirect overhead costs that the Medicare program would reimburse for these ancillary services.[16]

The Intermediary contends that it relied on the provisions of 42 C.F.R. § 413.9 and HCFA Pub. 15-1 § 2103 in determining that the OT and ST purchased services were in excess of the "going price" and substantially out of line compared to similar providers in the area. The Intermediary contends that the Provider failed to produce "clear justification" for its excessive costs. The Intermediary respectfully requests the Board to affirm its adjustment. In retrospect, the Intermediary believes $96 per hour for these purchased therapy services would be more appropriate for this rural Provider.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law- 42 U.S.C.:

§ 1861(v)(1)(A)	-	Reasonable Cost

2. Regulations-42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9 et seq	-	Cost Related to Patient Care
§ 413.30	-	Limitations on Reimbursable Costs

3. Program Instructions-Provider Reimbursement Manual, Part 1, (HCFA Pub.15-1):

§ 2103	-	Prudent Buyer

4. Program Instructions-Medicare Intermediary Manual (HCFA Pub. 13-2):

§2130.1	-	Prudent Buyer

[16] Intermediary Position Paper at 6.

5. Cases:

Bowen v. Georgetown University 488 U.S. 204 (1988).

Lakeland Manor Nursing Center (Chicago, IL.) v. Aetna Life Insurance Company, PRRB Dec. No. 91-D34, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶39,153.

Heather Manor Nursing Center (Harvey, IL) v. Aetna Life Insurance Company, PRRB Dec. No. 91-D35, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,154.

Oxford Lane, Ltd. (Naperville, IL) v. Aetna Life Insurance Company, PRRB Dec. No. 91 - D36, April 3, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,178.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after consideration and analysis of the controlling law, regulations and manual guidelines, the facts of the case, parties' contentions, and documentary evidence, finds and concludes that the Intermediary's audit adjustments were derived from an improper application of the Medicare program's reasonable cost doctrine. The reductions applied by the Intermediary to the costs incurred by the Provider for the OT and ST services obtained under arrangements with an outside therapy contractor were not imposed consistent with the reasonable cost limitations established by the governing provisions of 42 C.F.R. § 413.9. It is the Board's conclusion that the Provider's costs of OT and ST services obtained from outside contractors were reasonable and are fully allowable in determining reimbursable costs under the Medicare program.

Based on the facts presented in this case, the Board finds that the cost adjustments at issue concern reasonable cost determinations which the Intermediary applied to the Provider's cost report as part of its audit/settlement of the cost reporting period at issue. The Board finds no basis for the Provider's argument that this case involves the Intermediary's retroactive establishment of cost limits. The record is void of any evidence which would support the premise that the Intermediary's survey was authorized and performed under the cost limitation rules and procedures of 42 C.F.R. § 413.30, and that the results of the survey would be universally applied by HCFA to Medicare-certified SNFs participating in the Medicare program. Moreover, the Board notes that in its position paper, the Intermediary asserts that it was notified by HCFA to review for occurrences where providers were paying excessive amounts for contracted occupational therapy and speech therapy services.[17] As a result of this notification, the Intermediary contends that it conducted a survey of its providers to determine the "going price" being charged for contracted OT and ST services. The Board notes that the notification referred to by the Intermediary, in which HCFA presumably detailed the scope of its requested review, was not in evidence.

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[17] Intermediary Position Paper at 2.

In support of its reasonable cost determinations, the Intermediary takes the position that its survey demonstrated that the costs incurred by the Provider were over and above the going rate, and thus, were unnecessarily incurred under the the prudent buyer concept set forth under HCFA Pub. 15-1 § 2103, and were substantially out of line compared to similar providers in the area pursuant to the regulations at 42 C.F.R. § 413.9.

The regulation at 42 C.F.R. § 413.9 sets forth the Medicare program's basic tenet for the reimbursement of reasonable cost related to the provision of patient care. The regulation broadly defines reasonable cost by stating:

> (c) Application. (1) It is the intent of Medicare that payments to providers of services should be fair to the provider, to the contributors to the Medicare trust funds, and to other patients.
>
> (2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. <u>This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors</u>.

42 C.F.R. § 413.9(c) (emphasis added).

The Board recognizes that there are a number of problems that inhibit the effective exercise of the authority established under the regulation for the disallowance of incurred costs that are not reasonable. The disallowance of costs that are substantially out of line with those of comparable providers is generally limited to instances that can be specifically proved on a case-by-case basis, and clear demonstration of the specific reason that a cost is high is generally very difficult. However, this does not relieve the Intermediary of its burden to prove that the Provider's costs of OT and ST services were substantially out of line with other institutions in the same area that are similar in size, scope of service, utilization and other relevant factors. While the Intermediary's argument focused on the "substantially out of line" doctrine, the Board finds that there is simply not enough evidence in the record to adequately support the Intermediary's position. The record is void of any evidence that the Intermediary compared the Provider to institutions that were "similar in size, scope of service, utilization and other relevant factors."

Concerning the Intermediary's other position that the Provider violated the prudent buyer concept, as noted in the program instructions at HCFA Pub. 15-1 § 2103, the Board finds the Intermediary's brief argument, that the $120 rate paid by the Provider was not prudent in relation to the Intermediary's rate of $104, unconvincing. The Board finds that the survey at Intermediary Exhibit I-1 did not contain enough documentation to adequately support its prudent buyer argument.

Throughout its review of the case, the Board looked to the Intermediary's survey at Exhibit I-1. The Board notes that the last page of this survey is simply a listing of cities, counties, and certain rates for OT and ST. There is no indication in the record whatsoever of how the rates on this sheet transform into a rate of $104 per hour of service for OT and ST, which is the rate the Intermediary used to limit the Provider's reimbursement. Therefore, the Board concludes that this listing, purported to be a survey by the Intermediary, simply does not support a rate of $104 per unit of treatment.

DECISION AND ORDER:

The Intermediary's audit adjustments in which it cited the provisions of 42 C.F.R. § 413.9 and HCFA Pub. 15-1 § 2103 in determining that the OT and ST purchased services were in excess of the "going price " and substantially out of line compared to similar providers in the area were not proper. The Intermediary's adjustments are reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

Date of Decision: August 20, 1999

For The Board

Irvin W. Kues
Chairman