PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D76

PROVIDER -
Sterling Health Services, Inc.
Kansas City, Missouri

Provider No. 26-7281

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Wellmark, Inc.

DATE OF HEARING-
October 29, 1999

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-0455

INDEX

ISSUES:

1. Was the Intermediary=s adjustment disallowing salaries and benefits proper?

2. Was the Intermediary=s adjustment to automobile expense proper?

3. Was the Intermediary=s adjustment to square footage proper?

4. Was the Intermediary=s adjustment reversing the Provider=s reclassification of physical therapy costs proper?

5. Was the Intermediary=s adjustment to physical therapy salaries and benefits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sterling Health Services, Inc., (AProvider@) operated its home health agency in Kansas City, Missouri during 1995. On January 5, 1997, the Provider sold most of its assets to Health Cor, Inc. and ceased doing business. Wellmark, Inc., (referred herein as the AIntermediary@) issued a Notice of Program Reimbursement (ANPR@) to the Provider on September 22, 1997.[1] The NPR effected various adjustments to claimed costs/statistics as noted in the above referenced adjustments.[2] The Provider filed a timely notice of appeal with the Provider Reimbursement Review Board (ABoard@) on December 15, 1997[3], and has met the jurisdictional requirements of the regulations at 42 C.F.R. '' 405.1835-.1841. The Medicare effect of the adjustments is approximately $ 79,000.

The Provider was represented by Charles F. MacKelvie, Esq. of MacKelvie and Associates, P.C. The Intermediary was represented by James R. Grimes, Esq. of the Blue Cross and Blue Shield Association.

ISSUE NO. 1 - Disallowance of salaries and benefits

FACTS:

The Intermediary determined that 100 percent of the Program Coordinator=s position and 20 percent of the Administrator=s position were responsible for overseeing and participating in the marketing efforts of the Provider. The Intermediary adjusted to reclassify the salaries and benefits related to the nonallowable activities to a nonreimbursable cost center.

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[1] Provider Exhibit 1.

[2] See also Intermediary Position Paper Page 5.

[3] Provider Exhibit 2.

PROVIDER=S CONTENTIONS:

The Provider contends that all of the duties of the Administrator and the Program Coordinator were related to patient care, and as such the claimed compensation was reasonable. The Provider asserts that the Administrator=s job description approved by the Provider=s management, signed by the employee, and in existence as of October 1994 does not contain any mention of marketing or patient solicitation.[4] In addition, as all of the Administrator=s time was patient care related, she, as the Intermediary admits, was not required to keep time sheets.[5] Similarly, the job description of the Program Coordinator, which the Provider adopted by formal approval in January 1995, encompasses functions that are entirely patient care related.[6]

The Provider also contends that the job descriptions that the Intermediary used as the basis for its adjustment were not obtained from the Provider. Instead, the job descriptions were obtained from the successor corporation, as the Provider was not in business when the Intermediary performed its audit. Additionally, the Provider points out that the audit was performed without the Intermediary making an on site visit to the Provider. This resulted in the Intermediary making its adjustment without talking to those employees in the positions in question, or inquiring as to whether other signed job descriptions existed.

The Provider points to testimony at the hearing which indicated that its Administrator was very seriously ill during 1995 and was unable to meet with the public to perform any marketing activities.[7] With regard to the Program Coordinator, the Provider=s owner testified that the only functions performed by this person were patient coordination and helping the agency prepare for surveys and accreditation.[8] In addition, the Coordinator=s time sheets indicate that the Coordinator spent 100 % of her time in the office on patient care activities.[9]

The Provider further contends that the Intermediary=s application of HCFA Pub. 15-1, Section 2113 as a basis for adjustment is without merit. The Intermediary testified at the hearing that this section is not

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4 Attachment 1 to Provider=s Post Hearing Brief.

5 Tr. at p. 141.

6 Attachment 2 to Provider=s Post Hearing Brief.

7 Tr. at pages 35, 40, and 41.

8 Tr. at pages 43, 45, and 46.

9 Provider Exhibit 26.

applicable to the case at hand, in that HCFA Pub. 15-1, Section 2113 deals with intake coordination from the hospital to the Home Health Agency (HHA).[10] The Provider=s Coordinator did not perform that function.

Finally, the Provider contends that all of the compensation paid to the Administrator and Program Coordinator is reasonable in amount, as well as completely patient care related. In preparation for the Board hearing, the Provider reviewed all of the cost reports of comparable HHAs in the greater Kansas City area, as reported by Health Financial Systems (AHFS@).[11] The HFS data is received from HCFA and contains both audited and as-filed cost report information.[12] Based on this information, the Provider asserts that all amounts paid were reasonable.

INTERMEDIARY=S CONTENTIONS:

It is the Intermediary's contention that the audit adjustment to reclassify marketing salaries to a nonreimbursable cost center was made in accordance with the regulations at 42 C.F.R. ' 413.9 - Costs Related to Patient Care, and HCFA Pub. 15-1 ' 2102.3 - Costs Not Related to Patient Care, ' 2113.2 -Patient Solicitation Activities, ' 2136.2 - Nonallowable Advertising Costs, and ' 2328 Distribution of General Service Costs to Nonallowable Cost Areas.

Medicare regulation 42 C.F.R. ' 413.9(b)(2) states that:

> [N]ecessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

Its counterpart, HCFA Pub. 15-1 ' 2102.3 states, in part :

> [c]osts not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

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[10] Tr. at pages 140, 141.

[11] Provider Exhibit 24.

[12] Attachment 3 to Provider=s Post Hearing Brief.

HCFA Pub. 15-1 ' 2113.2 states :

> [c]osts incurred by a home health agency for personnel performing duties in the hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes. Visits made by HHA personnel to patients which have not yet been referred to the HHA... in order to persuade the patient to request the HHA's services are considered patient solicitation, as would visits to physicians to obtain referrals. Obtaining referrals by means of a cooperating hospital or SNF employee, or by reviewing patient records to identify potential patients for the HHA, are also considered patient solicitation. Any costs incurred for these activities are unallowable. These costs include not only the compensation and transportation costs of the HHA personnel engaged in the activity, but also any costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer patients to the HHA.

HCFA Pub. 15-1 ' 2136.2 states, in part:

> [c]osts of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective... general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients.

Id.

The Intermediary contends that these sections allow activities such as coordination, education and liaison, and professional contacts, but do not allow activities directed at increasing a provider's utilization. Medicare rules do not prohibit sales and marketing activities, but Medicare does not reimburse these costs.

The Intermediary also contends that the primary purpose of the Program Coordinator position appears to be to market the home health agency for the purpose of increasing the Provider's patient utilization. However, per HCFA Pub. 15-1 '2136.2, "costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable." Id.

The Intermediary's analysis of the Program Coordinator's job description[13] found that 100 percent of the activities were nonreimbursable. Items in the Program Coordinator job description that the Intermediary considers nonreimbursable would include the following (emphasis added):

> Initiates plans, and organizes a marketing/referral plan to coordinate referrals to Sterling in accordance with established policies.
>
> Establishes and maintains a referral base of physicians, insurers, and other health care providers to further expand Sterling's referral base.
>
> Maintains adequate documentation, to include: name, address, phone number, business cards, and brochures on all potential and established referral sources.
>
> Maintains weekly, monthly, and annual marketing reports and follow up documentation of all referral sources.
>
> Maintains the confidentiality of information for physicians, insurers and other health care professionals as it relates to Sterling's services and contractual agreements made with each provider.
>
> Conducts media releases, photo sessions, booths, and guest speaking engagements as necessary and maintains that marketing materials are current and plentiful.
>
> Acts as a liaison to conduct in problem solving when a problem has been identified which affects the future of referrals from new or established referral sources.
>
> Conducts competitive analysis within a specified time arrangement or an annual basis.
>
> Coordinates ideas for new programs with the Administrator, Director of Nursing, Director of Resource Information/Social Services, Director of Rehab, and Director of Total Quality Management.
>
> Orients all employees on the focus of marketing as new programs are developed.

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[13] Exhibit I-I-8.

> Provides guidance and leadership as required and coordinates marketing and new programs with each provider.
>
> Attends area network meetings to maintain knowledge of the competitive market and to assist Sterling in generating new ideas for program development as well as new referral patterns.

With respect to the Administrator=s position, the Intermediary points out that the job description[14] indicates that part of the responsibility of this position includes Amarketing to the referring community.@ The job description identifies that 20 percent of this position is responsible for the following nonreimbursable activities:

> Oversees and participates in the marketing efforts for the corporation, to insure that all target areas are being contacted appropriately.
>
> Participates in the development and implementation of the Corporation's marketing plan.
>
> Monitors the assigned marketing responsibilities by the proper staff.
>
> Markets a minimum of 10 hours per month outside the office.
>
> Reports on the marketing efforts and census on a weekly basis to the President/CEO.
>
> Insures the accuracy of public information materials and activities.

The primary purpose and function of these positions is to obtain and maintain patient referrals and to increase the Provider's patient utilization. The above items support the Intermediary's contention that these positions are clearly of a marketing and solicitous nature.

The Intermediary also notes that the Provider did not maintain time records that would have supported the patient care aspect of services rendered by these employees. Without auditable and verifiable time records, the Intermediary is unable to determine the actual time spent on any of the activities which might be characterized as allowable. The Program instructions at HCFA Pub. 15-1 ' 2113 clearly state that the Provider Amust be able to produce supporting records such as time logs to substantiate their statements pertaining to the time spent by HHA personnel in the various activities.@

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[14] Exhibit I-I-10

In summary, the Intermediary contends that 100 percent of the Program Coordinator's time, and at least a portion (20%) of the administrator position, was spent on patient solicitation, which is unallowable, and that the Provider has not submitted sufficient documentation to distinguish how much time was spent on allowable versus unallowable activities. The Intermediary contends that marketing costs that are determined to be nonallowable should be set up as a nonreimbursable cost center. They should absorb all related overhead costs associated with the nonallowable costs in accordance with HCFA Pub. 15-1 ' Section 2328.

In support of its position, the Intermediary points to Harriet Holmes Health Care Services v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 97-D43, April 7, 1997, Medicare and Medicaid Guide (CCH) & 45,169, decl=d rev. HCFA Admin. May 17, 1997, and the Administrator's decision dated August 4, 1996 which reversed the Board's decision in In Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, Iowa, Illinois and Wisconsin, PRRB Dec. No. 96-D36, June 10, 1996, Medicare and Medicaid Guide (CCH) & 44,477, aff=d. in part and modified in part HCFA Admin. August 4, 1996, Medicare and Medicaid Guide (CCH) & 44,594, rem=d HCFA Admin. Medicare and Medicaid Guide (CCH) & 46,141. In these decisions, the Board and the HCFA Administrator ruled that, Aabsent sufficient supporting documentation, several home health agencies' claims for Medicare reimbursement of the costs of home care coordinators/community liaisons were properly disallowed in full.. .the Intermediaries were correct to disallow the HCC/CL costs to the extent that the Providers did not provide detailed documentation to distinguish between allowable and nonallowable costs.. .the Intermediaries correctly created a nonreimbursable cost center for nonallowable HCC/CL costs...@ Id.

Issue No. 2 Disallowance of automobile expenses

FACTS:

The Intermediary disallowed $ 29,040 in claimed automobile expenses, stating that there was insufficient documentation to support the claimed cost.

PROVIDER=S CONTENTIONS:

The Provider contends that HCFA Pub. 15-1 ' 906.1 indicates that compensation includes personal usage of cars owned or leased by the provider. Medicare Intermediary Letter (IL) 78-16[15] also indicates that compensation includes personal use of an auto owned or leased by the provider. The Provider points out that the Intermediary has conceded that the compensation paid to the Provider=s

[15] Attachment 5 to Provider=s Post Hearing Brief

administrative staff is reasonable.[16] Therefore, even if the vehicle costs are all deemed to be personal, the Intermediary should have allocated those amounts to the respective employees as additional compensation.

The Provider also takes exception to the following statements made by the Intermediary on page 12 of its position paper:

1. There is a $13,858 variance between the lease costs and the total costs claimed. The Provider failed to furnish documentation to support this difference.

   Provider response: The Provider testified that it forwarded documentation to the Intermediary supporting every claimed auto expense on the general ledger.[17] Much of the documentation the Intermediary witness testified that he had never seen had been forwarded to the Intermediary audit staff.[18]

2. Mileage logs are not in sufficient detail capable of being audited.

   Provider response: There is unrefuted testimony in the record that the Intermediary was given the actual year ending odometer readings for 1994 for the three cars in existence.[19] The Intermediary witness testified that he never reviewed the 1994 audit file in preparation for the Board hearing.[20] The Provider=s owner also testified that the mileage given to the Intermediary during the audit is actual mileage readings at the end of 1995.[21] In addition, the Provider testified that personal vehicles were also used for business matters.[22]

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16 Tr. at p.149.

17 Provider Exhibit 18-1 & Tr. at p. 149.

18 Attachment 4 to Provider=s Post Hearing Brief

19 Tr. at pages 58, 59.

20 Tr. at page 146.

21 Tr. at p. 53.

22 Tr. at pages 55 & 59.

3. The cost per mile appears unreasonable.

> **Provider=s response**: The Provider contends that the Intermediary=s statement is made in the abstract as the Intermediary did not compare the auto costs of similar providers to the Provider. Based on the testimony above, if those individuals who used their personal vehicles for company business had always used the company provided leased vehicles the cost per mile would have been lower.

4. The employees estimated their personal mileage and estimates are not auditable.

> **Provider=s response**: Each of the employees had personal vehicles for their own personal use. The only personal use of the leased vehicles was for commuting and that distance could have been determined through employment records.

5. The personal mileage associated with the leased vehicles is not reported on the employee=s W-2s and reimbursement to the agency for personal use can not be verified.

> **Provider=s response**: The Provider contends that HCFA Pub. 15-1 ' 905.6 and IL 78-16 indicate that personal use of vehicles is considered compensation. The Provider employees, according to the Provider=s accountant, filed amended tax returns declaring the additional compensation.

The Provider also contends that the case law cited by the Intermediary is not applicable to the case at hand, in that the Intermediary has either lost or misplaced documentation sent by the Provider. The cases cited dealt with missing documentation.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Providers= costs were disallowed based on the following:

Unsupported Costs

The Provider claims that the additional $13,858 is for the cost of items such as gasoline, maintenance and repairs. However, the Provider did not furnish any documentation, during or subsequent to the audit, to support these costs.

It is the Intermediary's position that the Provider bears the burden of proving that they had the necessary documentation to support their claims for the auto costs. The Provider has failed to meet this burden,

and therefore, has not complied with the necessary documentation requirements of 42 C.F.R. ' 413.20(a), which requires that providers Amaintain sufficient financial records and statistical data for proper determination of costs payable under the program.@

Mileage Logs

The Intermediary contends that HCFA Pub. 15-1 ' 2114.2(B) states in part:

> [r]easonable costs of owned or leased vehicles incurred by an HHA to render necessary patient care are included in allowable costs of the HHA. When an HHA vehicle is used for personal and HHA patient care activities, the HHA must maintain documentation of the number of miles that the vehicle is used for each purpose...

The Intermediary contends that the mileage expense is not allowable for the following reasons:

The Provider's records do not meet adequacy of cost information requirements as set forth in HCFA Pub. 15-1 ' 2304 and the Medicare regulations 42 C.F.R. ' 413.24(c). To be considered adequate, the cost and statistical information must be:

- accurate,
- in sufficient detail to accomplish the purposes for which it is intended,
- capable of being audited, and
- maintained in a manner consistent from one period to another.

The Providers mileage logs do not meet any of the above requirements for the following reasons:

1. Odometer readings are not identified on the travel logs. Without Odometer readings, the Intermediary is unable to ensure the accuracy of the mileage claimed by the Provider.

2. The Provider states that the travel was for business purposes, and the employees reimbursed the agency for any personal usage. The Intermediary has several concerns with this statement. First, the employees have estimated their personal usage. Without actual mileage logs that identify the business and personal usage, the Provider can not accurately separate the mileage. Also, the Provider has failed to furnish documentation to support any reimbursement for personal usage.

3. The employees did not identify the purpose of their trips. Without a purpose of the trip, the Intermediary is unable to determine if it is related to patient care. The Provider claims that the employees used the leased vehicles for patient treatments, meetings with physicians and other health associations, purchasing office supplies, and visiting the bank and post office. The

Intermediary does not dispute that these are allowable business purposes for using the vehicles; however, the Intermediary contends that these trips are not adequately identified on the Provider's mileage logs.

4. The mileage logs are not kept daily. Mileage logs must be kept with actual mileage to determine that the logs are accurate and auditable.

In support of its position the Intermediary contends that in Call A Nurse v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D44, July 30, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,721, decíd. rev. HCFA Admin. September 11, 1992 the Board affirmed the Intermediary=s adjustment which disallowed mileage expense that was not adequately documented by the mileage logs maintained by the employees. The Board concluded, A[t]he Provider failed to document that the travel expenses were related to patient care.@ The Intermediary concludes that the facts and circumstances in the instant case are similar to Call A Nurse in that the Provider did not document that the expenses are related to patient care.

Personal mileage

It is the Provider=s policy for the employees to reimburse the company for the personal use of the autos; therefore, the Provider does not claim the personal mileage on the employee W-2 forms. The Intermediary is unable to verify that the employees actually reimbursed the company for personal usage as the Provider has not furnished documentation to support that any payments were made. Furthermore, the Provider can not accurately calculate an amount related to the personal usage, as the employees have used estimates to record their personal miles.

Issue No. 3 Square Footage Adjustment:

FACTS:

In its as filed cost report, the Provider submitted square feet as the statistic to allocate its capital related costs. The square footage of 5100 was allocated as follows: 2146 to A&G, 2714 to skilled nursing, 48 to medical social worker, 96 to home health aide, and 96 to supplies. However, the Intermediary determined that the floor plans were not sufficient to support the allocation and adjusted to allocate 100 percent of the square feet to the Administrative and General cost center.

PROVIDER=S CONTENTIONS:

The Provider contends that it accurately allocated its square feet to the appropriate cost centers after its owner personally measured the rented space. The Provider leased 5400 square feet from its landlord and had submitted detailed floor plans to the Intermediary for its 1993 and subsequent fiscal years,

including where its clinical and administrative personnel were located.[23] During the audit, the Provider=s owner and his assistants explained to the Intermediary how the Provider allocated square feet, who was located in the space, and drew detailed plans to explain its position. At the hearing, the Provider=s witness explained in detail which employees and employee functions utilized the space.[24]

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Provider has not met the documentation requirements of 42 C.F.R. ' 413.20(a). The Provider=s submitted floor plans are not in sufficient detail capable of verification for the following reasons:

1. The total square feet per the cost report does not tie to total square feet per the floor plans. The Provider has submitted two different floor plans; one identifies total useable square feet as 5,324 and the other identifies rentable square feet of 6,225. Both floor plans show total square feet of 7,075. Neither plan supports the total square feet of 5,100 as reported on the cost report.

2. The floor plans do not identify separate areas or who occupies these areas. In the absence of documentation identifying how the space is occupied, the Intermediary is unable to verify the accuracy of the submitted statistics.

Issue No. 4 - Intermediary=s reversal of Provider=s reclassification of PT costs.

FACTS:

In its as filed Worksheet A-8-3, the Provider calculated an excess of $15,445 over the physical therapy cost guidelines. The Provider reclassified these costs from the physical therapy cost center to the administrative and general cost center. The Intermediary reversed the Provider=s reclassification.[25] At the hearing, both parties agreed to allow this issue to be resolved on the record.[26]

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[23] Tr. at pages 64-67.

[24] Tr. at pages 65-67.

[25] Intermediary Exhibit 22.

[26] Tr. at p. 15.

PROVIDER=S CONTENTIONS:

The Provider did not address this issue in its position paper or post hearing brief.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment was made in accordance with HCFA Pub. 15-2 Chapter 32- Home Health Agency Cost Report instructions, sections 3206, 3211, and 3219.[27] These instructions state that cost in excess of physical therapy guidelines, as calculated on Worksheet A-8-3, are to be included on Worksheet A-5 as an adjustment and removed from total physical therapy costs on Worksheet A, not shifted to another cost center. The Intermediary contends that its adjustment ensures the proper flow of the cost report.

Issue No. 5 - Adjustment to PT (physical therapy) salaries and benefits

FACTS:

This adjustment includes a recalculation of physical therapy visits/hours on Worksheet A-8-3 as well as a reclassification of physical therapy salary and benefit costs from the skilled nursing cost center to the physical therapy cost center. Specifically, the Intermediary reduced total PT visits by 468 and also adjusted PT hours to equal 1 hour per visit.[28] Secondly, the Provider employed three physical therapists who were paid a total of $ 22,982. Of that amount, the Provider reported only $ 7,002 in the physical therapy cost center. The remainder was charged to the skilled nursing cost center. Upon review, the Intermediary reclassified $17,665 in salary and benefit costs from skilled nursing to the physical therapy cost center.[29]

At the hearing, the Provider indicated that it did not understand the basis for the adjustments and would like the issue to be resolved based on the record.[30] The Provider=s position paper and post hearing brief argue an issue which is completely different than those noted above.

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[27] Intermediary Exhibit 21.

[28] Intermediary Position Paper 19 & Intermediary Exhibit 19.

[29] Intermediary Exhibit 19.

[30] Tr at p. 14.

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary adjusted the compensation paid to outside PT contractors based on the Medicare instructions governing what outside contractors should be paid. However, they did not properly apply the Salary Equivalency Guidelines (AGuidelines@). The Provider points to 42 U.S.C. ' 1395x(v)(5)(A) and the implementing regulation 42 C.F.R. ' 405.432 (now ' 413.106) as the authority for adoption of the Guidelines.

The Provider also contends that by not updating the Guidelines to 1995, the Intermediary issued a Notice of Program Reimbursement (NPR) which contained a substantial downward adjustment to the Provider=s claimed costs. In applying those Guidelines without updating, the Intermediary ignores the applicable Statute and regulation.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment to PT visits/hours was made in accordance with HCFA Pub. 15-1 ' 2304. The Provider reported total physical therapy visits on Worksheet A-8-3 but only the costs related to the contracted physical therapy services were correctly reported on Worksheet A-8-3. Accordingly, the adjustment was made for purposes of consistency.

The Intermediary also contends that HCFA Pub. 15-2 ' 3206 provides specific instructions for reporting Skilled Nursing and Physical Therapy services. They are:

> Line 6- Skilled nursing care is a service that must be provided by or under the supervision of a registered nurse. The complexity of the service , as well as the condition of the patient, are factors to be considered when determining whether skilled nursing services are required.
>
> Line 7 - Enter the direct costs of physical therapy services by or under the direction of a registered physical therapist as prescribed by a physician. The therapist provides evaluation, treatment planning, instruction, and consultation.

The Intermediary contends that Medicare instructions clearly define skilled nursing and therapy services and the handling of these costs on the cost report. The Provider has not presented any documentation to support its classification of a portion of its physical therapy costs to the skilled nursing cost center. The Intermediary also points out that this portion of the adjustment has a positive reimbursement effect to the Provider, in that the Medicare utilization is higher for the physical therapy cost center than the skilled nursing cost center.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.

' 1395x(v) et seq.	-	Reasonable Cost

2. Regulations 42 C.F.R.

' 405.432(now 413.106)	-	Reasonable Costs of Physical and Other Therapy Services Furnished Under Arrangements
'' 405.1835-.1841	-	Board Jurisdiction
' 413.9 et. seq.	-	Cost Related to Patient Care
' 413.20 (a)	-	Financial Data and Reports-General
' 413.24	-	Adequate Cost Data and Cost Finding
' 413.24 (c)	-	Adequacy of Cost Information

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

' 905.6	-	Types of Compensation-Corporations
' 906.1	-	Other Types of Compensation
' 2102	-	Definitions
' 2102.3	-	Costs Not Related to Patient Care
' 2113 et. seq.	-	Home Health Coordination
' 2114.2 (B)	-	Use of an HHAs Vehicle
' 2136.2	-	Nonallowable Advertising Costs
' 2304	-	Adequacy of Cost Information

' 2328	-	Distribution of General Service Costs to Non-allowable Cost Centers

4. Program Instructions Provider Reimbursement Manual Part II (HCFA Pub 15-2)

' 3206	-	Worksheet A-Reclassification and Adjustment of Trial Balance of Expenses
' 3211	-	Worksheet A-5 -Adjustment to Expenses
' 3219	-	Supplemental Worksheet A-8-3 Reasonable Cost Determination For Physical Therapy Services Furnished By Outside Suppliers

5. Other

Medicare Intermediary Letter (IL) 78-16

5. Cases

Harriet Holmes Health Care Services v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Case No. 97-D43, April 7, 1997, Medicare and Medicaid Guide (CCH) & 45,169, decl=d. rev. HCFA Admin. May 17, 1997.

In Home Health Inc. v. Blue Cross and Blue Shield Association/Blue Cross Blue Shield of California, Iowa, Illinois and Wisconsin, PRRB Dec. No. 96-D36, June 10, 1996, Medicare and Medicaid Guide (CCH) & 44,477, aff=d. in part & modified in part HCFA Admin. August 4, 1996, Medicare and Medicaid Guide (CCH) & 44,594, rem=d. HCFA Admin. Medicare & Medicaid Guide (CCH) & 46,141.

Call A Nurse v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 92-D44, July 30, 1992, Medicare & Medicaid Guide (CCH) & 40,721, decl=d. rev. HCFA Admin. September 11,1992.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and the post hearing brief, finds and concludes as follows:

Issue 1. - Disallowance of salaries and benefits:

The Board finds and concludes that the Intermediary=s adjustment was proper and bases its determination on the regulation at 42 C.F.R. ' 413.9 which discusses the allowance of costs related to patient care, and the program instructions at HCFA Pub. 15-1 ' 2102, and ' 2136.2.

The pertinent regulation reads:

> [N]ecessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider=s activity.

This is repeated in the manual counterpart at HCFA Pub. 15-1 ' 2102. In addition, the HCFA Pub. 15-1 ' 2136.2 states in part A[c]osts of advertising to the general public which seeks to increase patient utilization of the provider=s facilities are not allowable. Situations may arise where advertising which appears to be in the nature of the provider=s public relations activity is, in fact, an effort to attract more patients.@ Id.

Applying the above regulatory and manual requirements to the instant case, the Board finds that the Provider=s claimed costs did not meet the established requirements. Specifically, the Board finds that the job descriptions in the record do not support the Provider=s contentions. A review of those job descriptions finds that the primary focus in both positions was on marketing and patient solicitation activities. While Medicare rules do not prohibit sales and marketing activities, the Medicare program does not reimburse these costs. In addition, the Board could not determine the validity of the two new job descriptions submitted with the Provider=s post hearing brief.

Also absent from the record were time sheets which could have supported the patient care aspect of the services rendered by the two employees in question. Without this information, the Board was unable to determine the actual time spent on any of the job activities which may have been viewed as allowable. In view of these factors, the Board finds that the best evidence in the record supports the Intermediary=s adjustment.

Issue 2. - Disallowance of automobile expenses:

The Board finds that the Provider was only able to identify total miles driven based on odometer information. Daily mileage logs were not maintained which prevented the Intermediary from determining what costs, if any, were related to patient care.

The Board finds that the Intermediary was correct in requiring adequate data to support the claimed auto expenses. 42 C.F.R. ' 413.24 requires that the cost data must be accurate, in sufficient detail to

accomplish the purpose for which it is intended, and also be capable of being audited. In addition, the manual instructions at HCFA Pub. 15-1 2114.2(B) state in part:

> [R]easonable costs of owned or leased vehicles incurred by an HHA to render necessary patient care are included in allowable costs of the HHA. When an HHA vehicle is used for personal and HHA activity, the HHA must maintain documentation of the number of miles that the vehicle is used for each purpose.

In the instant case, the Provider was only able to identify estimated commuting/personal mileage.

The Board was also unable to concur with two additional arguments advanced by the Provider. First, the Provider contended that personal use of vehicles is considered to be compensation and that the Provider=s accountant filed amended income tax returns to declare the additional compensation. Alternatively, the Provider argues that the Intermediary should have automatically reallocated all of the disallowed automobile expense as additional compensation.

The Board was unable to determine, from the record, that the employees either reimbursed the Provider for the personal auto usage or filed amended income tax returns as contended. In addition, the Intermediary can not accurately calculate an amount related to personal auto usage, as only estimates were used by the Provider to define personal mileage. Also, testimony at the hearing indicated that significant, original documentation may have been forwarded to the Intermediary. However, copies were not maintained by the Provider. Accordingly, the record is devoid of sufficient documentation to support the Provider=s position.

Issue 3. - Square footage adjustment

The Board notes that the Intermediary adjusted 100% of the square footage to the A&G cost center, stating that the Provider=s floor plans were not detailed enough to ascertain if the allocation of square feet was accurate. The evidence indicates that the Provider submitted a detailed floor plan to the Intermediary for the December 31, 1993 fiscal year and subsequent years. This plan contained a breakdown and assignment of personnel to the various cost centers. At the hearing, the Provider witness testified and presented a floor plan that indicated which employees/functions occupied the space in question. A nominal discrepancy of approximately 110 square feet appears to be unusable storage space.

The Board finds that the evidence submitted is sufficient to reasonably confirm the Provider=s allocation of space.

Issue 4. - Intermediary reversal of Provider=s reclassification of PT costs

The Board finds that the Intermediary adjustment to reclassify physical therapy costs was made in accordance with HCFA Pub. 15-2 Sections 3206, 3211, and 3219, which ensures the proper flow of the Medicare cost report. The Board notes that the Provider did not address this issue in its position paper or the post hearing brief.

Issue 5. - Adjustment to PT salaries and benefits

The Board finds that this adjustment contained two parts. First, the Intermediary recalculated allowable physical therapy visits and hours in accordance with HCFA Pub. 15-1 ' 2304. Secondly, the Intermediary reclassified salary and benefit amounts from the skilled nursing cost center to the physical therapy cost center. This was done in accordance with the instructions in HCFA Pub. 15-1 ' 3206. The Board finds that the Intermediary properly followed the Medicare cost reporting instructions. Furthermore, the Provider=s contentions and arguments do not properly address the issues at hand.

DECISION AND ORDER:

Issue 1. - Disallowance of salaries and benefits

The Intermediary=s adjustment reducing salaries and benefits was correct. The Intermediary=s adjustment is affirmed.

Issue 2. - Disallowance of automobile expenses

The Intermediary=s adjustment of the Provider=s automobile expenses was proper. The Intermediary=s adjustment is affirmed.

Issue 3. - Square Footage Adjustment

The Provider=s floor plan and testimony at the hearing properly identified the square feet to be used as the statistic for allocating capital costs. The Intermediary=s adjustment is reversed.

Issue 4. - Intermediary reversal of Provider=s reclassification of PT costs

The Intermediary=s adjustment to reclassify therapy costs was proper. The Intermediary=s adjustment is affirmed.

Issue 5. - Adjustment to PT salaries and benefits

The Intermediary=s adjustments to therapy salaries/benefits, and therapy visits/hours were proper. The Intermediary=s adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: August 18, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman