PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2002-D24

PROVIDER – Easley Nursing Center Easley, South Carolina	**DATE OF HEARING** October 17, 2001
Provider No. 42-5018	Cost Reporting Period Ended - September 30, 1997
vs.	
INTERMEDIARY – Blue Cross and Blue Shield Association/ Palmetto Government Benefits Administrator	**CASE NO.** 01-0198

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ISSUES:

1. Was the Intermediary's adjustment combining all SNF and NF cost charges, days, and statistics into one cost center proper?

2. Was the Intermediary's determination that payroll records were not adequate to support nursing service cost allocation to the SNF distinct part proper?

3. Was the Intermediary's determination that the allocation of nursing time resulted in an inequitable allocation of cost to the SNF distinct part proper?

4. Was the Intermediary's decision to disregard statistics and supporting documentation for the allocation of all other general service costs to the SNF distinct part proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Easley Nursing Home ("Provider") is a 103-bed nursing home with a 26-bed certified distinct part, and is located in Easley, South Carolina. The Provider is managed by Health Management Resources ("HMR"), also in Easley. HMR also manages Westside Nursing Center, Greenville, South Carolina, and Summit Place, a nursing facility located in Simpsonville, South Carolina. The three nursing facilities and HMR are related parties by common ownership.

The Provider used a system that assigned employees to home departments that included direct care nursing departments for the Certified Distinct Part ("CDP") and the non-certified area Nursing Facility ("NF") to separately accumulate nursing service hours for costs allocation. The time was automatically assigned to each employee's home department for payroll costing purposes when the employee clocked in with his/her electronic card. The system also allowed for manual entries to be made to redirect hours and costs for instances when an employee worked in a department other than the employee's home department.

To facilitate the redirection of hours and allocation of costs, manual entries were performed on a daily basis based on records made at the time the services were rendered. These records were the source documents prepared by employees who were either assigned to the CDP home department or who worked on the CDP but were assigned to different home departments.

Nursing service personnel received in-service training with regard to record-keeping requirements. Nurses, nurse's aides and other applicable personnel were instructed to enter the times that they worked on the unit and to authenticate such entries by their signature. The training did not stipulate that the times between the time clock and the source documents had to exactly match.

The Payroll system develops several separate yet related records that include (1) Time Card Report, (2) Distributed Hours Report, and (3) Period Totals Report. The Time Card Report recorded the daily in and out times generated by the card swipes and a summary of the total

hours and costs allocated to departments in which each employee worked. The Distributed Hours Report and the Period Totals Report only reflected the total hours and costs allocated to departments in which each employee worked.

Palmetto Government Benefits Administrator ("Intermediary") reviewed the Provider's payroll records and supporting documentation and determined that they were not adequate to support the direct assignment of hours and allocation of nursing services costs. The Intermediary adjusted by combining all charges, costs, patient days and statistics to the Skilled Nursing Facility ("SNF") lines on the appropriate worksheets of the cost reports. This resulted in the averaging of the directly assigned nursing services costs and all allocated general service (indirect) costs. The Provider disagreed with the Intermediary's disallowance and requested a hearing by the Provider Reimbursement Review Board ("Board"). The Board reviewed the Provider's request and found that it did have jurisdiction based on the regulations at 42 C.F.R. § 405.1835-.1841. The amount of reimbursement in contention is approximately $296,665.

While the appeal was pending, the Provider reviewed seven additional payroll periods throughout the cost reporting period and submitted comparisons noting the variances between the time cards and the employee sign-in sheets. The Intermediary reviewed the additional documentation and determined that the new information was not sufficient to set up a distinct part.

The Provider was represented by R. Bruce McKibben, Jr., Esq., of R. Bruce McKibben, P.A. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the errors identified by the Intermediary were the result of minor errors and inconsistencies due to variances between the times entered on the sign-in sheets and the times recorded by the automatic clock. As an example, Employee A may have clocked in to work at 6:56 A.M. but signed in on the Sign-in/out sheet at 7:07 A.M., a discrepancy of eleven minutes. As a result of the audit the Intermediary concluded that the numbers and percentages of errors were too high to allow the records to be used as a basis for substantiating nursing service cost allocation.

The Provider argues that the Intermediary violated the zero tolerance policy set forth by Charles R. Booth, former director of CMS' cost policy. Mr. Booth's policy states in part that "Minor errors and inconsistencies in the SNF's recordkeeping and cost allocation system" are not to result in determinations of inadequacy.[1]

The Provider points out that the Intermediary reviewed its records consisting of Time Card

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[1] See Exhibit P-10.

Reports and Sign-in/out sheets for its 8/27/97 pay period and cited discrepancies in the records for 7 of the 8 employees reviewed; an error rate of 87.5%. The discrepancies included:

1. Four employees were cited for the failure to record "in" and/or "out" times on the source documents, even though the times were readily available on the Time Card Report and the entries for that day were dated and authenticated by the employees' signatures.

2. One employee, assigned to the CDP on the night shift on weekends, failed to record entries for 0.75 hour and 1.0 hour on the source documents for required meetings and/or training held during daytime hours during the week.

3. Two employees should not have been reviewed, as they were not included in the CDP home department nor did they have hours and costs recorded to the CDP.

The Provider is not in agreement with the Intermediary's contention regarding major errors ranging from "80 something percent to 94%, and 60% to 70%." The Provider maintains that for substantiating staffing during the period, any variances within +/- 1%, 3%, or 5% of total hours in the period are within the realm of minor errors. When using the most stringent criterion, that of variances in excess of +/- 1% of each pay period's total hours as being major errors, the collective ranges for the three Providers (Easley, Westside, and Summit) were 4.5% to 24.3%, with a composite 15.6% for the group. When using the more reasonable parameters of excesses greater than +/- 3% and +/- 5%, the composite for the group was 4.4% and .1% respectively.[2]

The Provider argues that the samples as designed and as administered by the Intermediary were not representative of the fiscal period in dispute. The Intermediary reviewed samples that were not a representative standard for the entire fiscal period being audited, either by design or in actuality. The Intermediary's designed sample was composed of two pre-selected periods, and then it was further reduced by only reviewing every 5th employee in each pay period. The design of the sample represented less than 2% of the records of the applicable employees when extrapolated over the entire fiscal year.

The Provider contends that the Intermediary should have expanded the sample. Pursuant to the Program Memorandum Intermediary Transmittal I-82 ("PMI"), intermediaries are instructed that if the test results indicate probable errors in the universe, the auditors must document the decision to either expand the sample or project the error to the universe. Neither of these prescribed actions was evident in the audits of the Providers.

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[2] See Provider post hearing brief page 7.

The Provider also points out that not only did the Intermediary not expand the sample, in 2 of the 3 instances the Intermediary reduced the samples tested to half of the original design. The PMI instructions indicate that under no circumstances should a sample's error be expanded to the universe without considering the effect on the universe; it is evident that this instruction was also ignored. The expansion to the universe resulted in an absolute inequitable allocation of costs.

The Provider contends that the requirements for the equitability of the nursing services costs are set forth in § 2340.l of CMS Pub. 15-1, which states that:

> [r]egardless of the method used, the result should be an equitable allocation of the nursing service costs between the distinct part and other parts of the facility based on records or notations made at the time the services were rendered.

The Provider contends that it met the above mentioned requirement and that the allocation of nursing service costs were, in fact, equitable prior to the adjustment. The Intermediary's expansion to the universe and resulting adjustments generated inequities of cost allocations to the skilled nursing area and other parts of the facilities.

The Provider argues that it was denied reimbursement for its reasonable costs associated with the care and treatment of Medicare beneficiaries in a distinct part of a nursing home guaranteed by the regulation at 42 C.F.R. § 413.5. The Provider points out that CMS Pub. 15-1 § 2340 does not provide, nor does it permit, nor does it allow, the combining of costs, patient days and statistics for the certified and non-certified areas into one line on the cost report.

The Provider contends that it was improper for the Intermediary to reject its documents. The Provider's Time Card Reports and Sign-In Sheets did accomplish their intended purpose; they reflected the times worked by various individuals at the subject facilities. The records found by the Intermediary to be inadequate as a result of minor discrepancies and/or omissions were based on a zero tolerance criterion and are contrary to Medicare regulations. The records were rejected because the entries didn't exactly match and the records were not letter perfect.

The Provider maintains that the Board has long held that letter perfect documentation is not required for supporting costs and cost allocation. Such is exemplified by the Board's use of daily schedules and average hourly rates to arrive at nursing services costs in Glencrest Rehabilitation Center, Chicago, IL v. Aetna Life and Casualty Co., PRRB Dec. No. 90-D8, Dec. 12, 1989 Medicare and Medicaid Guide (CCH) ¶ 38,286,aff'd HCFA Adm., February 2, 1990 Medicare and Medicaid Guide (CCH) ¶ 38,368 and the Board's use of floor-wide average nursing cost per diem to compute nursing hours for the certified area in Bridgeview Convalescent Center, Bridgeview, IL v. Aetna Life Insurance Co., PRRB Dec. No. 89-D66, September 27, 1989, Medicare and Medicaid Guide (CCH) ¶ 38,216, aff'd, HCFA Adm., November 22, 1989 Medicare and Medicaid Guide (CCH) ¶ 38,278. Also, in Imperial Hospital, Richmond, VA v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 80-D39, June 30, 1980, Medicare and Medicaid Guide (CCH) ¶ 35,355, the

Board disregarded the fact that primary source documents were not available due to having been lost, and it relied upon industry norms to support and allow reimbursement for reasonable costs.

The Provider maintains that there were fundamental problems with how the Intermediary conducted the audit and its reliance on only a limited number of documents. The auditors, pursuant to their own rules, asked for records for two pay periods for the year at issue. Then they reviewed 20% or less of the employee records in the selected periods. The Provider argues that representative statistical samples were not used by the auditors. In addition, probable errors in the universe were not addressed by expanding the sizes of the non-representative samples.

The Provider contends that it has substantiated that the care and services provided exceeded the peer group as evidenced by the presence of atypical patients requiring atypical services. It is obvious that the Intermediary's adjustments have resulted in unquestionable inequities of allocation of costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to maintain adequate and verifiable documentation to support its allocation of nursing service costs to the CDP and NF units of the facilities. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, a provider is required to maintain sufficient financial records and adequate cost data to assure the proper determination of costs under the Medicare program. The recordkeeping requirement includes the concept that data be accurate, maintained in sufficient detail to accomplish its intended purpose, and must be capable of verification by a qualified auditor.

The Intermediary argues that the Provider's reliance on Sign-In Sheets to support the payroll system to split the nursing time and cost between the CDP and the NF was not adequate. The error rate in time reporting from the Sign-In Sheets was significant for all Providers. The Provider's system relies on facility personnel to manually correct payroll records to account for time spent in a department different from the employee's home department. There were many instances of errors and failure to accurately make the manual changes. The evidence established that the payroll record, which is the basis of the Provider's time split, is not accurate and does not meet the substantiation requirements of the regulations.

The Intermediary points out that CMS Pub. 15-1 § 2340.1 presents two methods to allocate nursing service cost between a CDP and a non-CDP. The first method is based on actual time. The second method uses one average cost per hour equally in both units. The Provider attempted to discretely identify time spent by its staff as between the CDP and NF. The Intermediary determined that the methodology for charging time did not adequately identify actual time, was not capable of audit and otherwise did not provide adequate documentation to support the differential in nursing costs claimed in each section of its facility. As a result, the Intermediary reclassified direct nursing costs between the two cost centers based upon calculating an overall average cost per diem.

The Intermediary points out that it requested time reporting records for two time periods. The Intermediary determined that the Provider maintained time record reporting systems which tied into the payroll system and that the payroll then determined the time split between nursing costs assigned to the CDP and the NF. The system appeared to be acceptable.[3] "However, after" the audit the Intermediary concluded that the time card records could not be relied upon to support the allocation between the CDP and the NF.

The Intermediary contends that its review of the additional pay "period data submitted" by the Provider further substantiates the inability of the Intermediary to rely on the Provider's time recording method. The Provider contends that the total percentage variances ranged from a negative 12.21% to a positive 11.90%. The Intermediary points out that while total variances according to the Provider's calculations may not be significant in certain pay periods, there is a substantial number of employees with significant variances between the Time Card Report and the Sign-In Sheet. The Intermediary notes that the negative variance in hours between the time cards and the Sign-In Sheet are negated by the positive. This creates an overall effect that is much lower than if each employee is reviewed individually. The Intermediary contends that the variances between the Time Card Reports and the Sign-In-Sheets should be absolute and not taken as a whole to determine total percentage variances. Based on the Provider's summary, "determination of Unsupported Hours," the variance in total hours reported between the Time Card Report and the Sign-In Sheet is significant for numerous employees.

Utilizing the Provider's calculations, the Intermediary contends that a variance in either direction substantiates the Intermediary's contention that the Time Card Reports do not support the Sign-In Sheets (or vice versa). For the seven periods under review the Intermediary found the following variances: 94%, 93%, 93%, 90%, 94%, 94%, and 88%.

The Intermediary concludes that it is unable to rely on the Sign-In Sheets and Time Card Reports in total. Therefore, it is unable to verify the accuracy of the Provider's allocation of salary expense between the SNF and NF cost centers.

The Intermediary contends that its review of the additional documentation supplied by the Provider confirms its conclusion that the time reporting system was not reliable.[4] The

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[3] Tr. at 285.

[4] Tr. at 294.

Intermediary witness pointed out that the additional documentation showed a 94% error rate in the time reporting system. Six of the listed employees had no sign-in sheets, and eight employees had no time records at all.[5] The Intermediary found examples of employees who reported time spent in both the CDP and the NF on their time sheets. Yet all of the employees' time was reported in the CDP on the payroll records.[6]

The Intermediary contends that given the serious flaws in the time reporting process, the use of the average time method was appropriate. Under CMS Pub. 15-1 § 2340(b)(2), the Intermediary could not make a finding that the allocations made through the use of the payroll system, with possible adjustments by the staff development director, were an accurate allocations of costs. It was at best an estimate without checks or balances. The Intermediary's adjustments which applied the average cost per diem method to determine direct nursing costs in the CDP and NF units of the Provider are supported by the facts and authorities.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations - 42 C.F.R.

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement General
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding

2. Program Instructions - Provider Reimbursement Manual (CMS Pub. 15-1):

§ 2340	-	Allocating Nursing Service Costs in Nursing Homes With Distinct Part Skilled Nursing Facility
§ 2340.1	-	Actual Time Basis

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5 Tr. at 295-6.

6 Tr. at 300.

§ 2340(b)(2) - Average Cost Per Diem

3. Cases:

Glencrest Rehabilitation Center, Chicago, IL, v. Aetna Life and Casualty Co., PRRB Dec. No. 90-D8, Dec. 12, 1989, Medicare and Medicaid Guide (CCH) ¶ 38,286, aff'd, HCFA Adm., February 22, 1990 Medicare and Medicaid Guide (CCH) ¶ 38,368.

Bridgeview Convalescent Center, Bridgeview, IL. v. Aetna Life Insurance Co, PRRB Dec. No. 89-D66, Sept. 27, 1989, Medicare and Medicaid Guide ("CCH") ¶ 38,216, aff'd, HCFA Adm., November 22, 1989 Medicare and Medicaid Guide (CCH) ¶ 38, 278.

Imperial Hospital, Richmond, VA v. Blue Cross and Blue Shield Assoc./Blue Cross and Blue Shield of Virginia, PRRB Dec. No. 80-D39, June 30, 1980, Medicare and Medicaid Guide (CCH) ¶ 35,355.

4. Other:

Program Memorandum Intermediary Transmittal I-82.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented at the hearing, finds and concludes the Intermediary properly combined all SNF and NF cost charges, days and statistics into one cost center. The Board finds that the Provider's records were not sufficient to allocate cost between the distinct part and the nursing facility.

The Board finds that the Provider's payroll system relies in part on facility personnel to manually correct payroll records to account for time spent in a department different than the employees' home department. There were many instances of errors and failure to accurately make the manual changes. The evidence established that the payroll record that is the basis for Provider's time split is not accurate and does not meet the substantiation requirements of the regulation.

The Board finds that the Intermediary did not pursue a zero tolerance policy in conducting the audit. The audit revealed errors and inconsistencies in the Provider's recordkeeping and cost allocation system which were not considered to be minor errors. Although the Intermediary did not specify what an error rate threshold would be, in response to the Board's questions, the Board finds that a significant number of the errors described by the Intermediary were major errors. The Board used CMS Pub. 15-1 § 2340.1, which stresses equitable allocation of costs, for guidance. Since the Intermediary found that the payroll records did not support the allocation of costs, the Intermediary is required to make an average cost adjustment to the cost report.

The Board finds that although many of the discrepancies between the time clock and the sign-in

and out sheets were minor, the 8-hour time sheet is not a reliable source with which to allocate costs. The Board notes that there were several large discrepancies on the sign-out sheets. These discrepancies included wrong room numbers, lack of sign in or sign out, and employee allocations being ignored. Most significantly, employees' own records that showed time spent in both the distinct part and the nursing facility was charged in some instances entirely to the distinct part. Despite the in-service training of its employees in the use of the time cards, there was no evidence of any follow-up by the Provider's administration, nor did there appear to be any good internal control on the part of the Provider's administrators.

The Board notes that the Provider did not provide any analysis of the impact of the stated error rate on the cost report. The Board also notes that the direct cost of $56 per diem for the distinct part and $25 per diem for the Nursing facility was not out of line for this type of facility. However, without proper documentation, the Intermediary was forced to utilize the average cost of the facility.

The Board concludes that the Provider failed to maintain adequate and verifiable documentation to support its allocation of nursing service costs to the distinct part and nursing facility. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, the Provider is required to maintain sufficient financial records and adequate cost data to assure the proper determination of costs under the Medicare program. The recordkeeping requirement includes the concept that data be accurate, maintained in sufficient detail to accomplish its intended purpose, and must be capable of verification by a qualified auditor. The Provider did not meet its obligations under this regulation.

With regard to the Provider's complaint that the sample audited was not representative and too small to be extrapolated to the universe of employee records, we find that the issue became moot when the Provider submitted error rate calculations for seven additional time periods of its own choosing and the Intermediary reviewed and considered those additional records.

DECISION:

The Board finds that the Provider's payroll system was not sufficient to support a proper cost allocation between the certified and non-certified areas of the facility. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: June 27, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman