PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D39

PROVIDER –
Jefferson Hills Manor
Pittsburgh, PA

Provider Nos.
39-5066

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Veritus Medicare Services

DATE OF HEARING-
February 2, 2001

Cost Reporting Periods Ended
June 30, 1994

CASE NO. 97-0403

INDEX

ISSUE:[1]

Was the Intermediary's adjustment to Medicare patient days proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Jefferson Hills Manor ("Provider") of Pittsburgh, Pennsylvania is an 83 bed skilled nursing facility ("SNF"). However, only 27 beds were certified for participation in the Medicare program. Upon audit, Veritus Medicare Services ("Intermediary") disallowed 1,311 Medicare days of service stating that those days of service were rendered outside of the Medicare distinct part.[2] The Provider appealed the Intermediary determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $156,000. The Provider was represented by Peter W. Kociolek, Jr., Esq., of Charles O. Barto, Jr. and Associates. Bernard M. Talbert, Esq., of the Blue Cross Blue Shield Association, represented the Intermediary.

PROVIDER'S CONTENTIONS:

The Provider contends that for three of its residents (20, 21 and 24) care was, in fact, provided, and the Intermediary erred by disallowing these days of care. Initially, the Provider placed these three (3) residents outside the distinct part because there was no room therein, but subsequently transferred the residents to the distinct part when a bed became available. The Provider contends there is no basis in the statute or the regulations for holding that a provider is liable for days of care provided to a Medicare resident in the distinct part because that resident was placed outside the distinct part at another time during his/her stay in the facility. For the period of time during which these three (3) Medicare residents received care in the Medicare distinct part, the Provider fulfilled all its responsibilities under the Medicare program and should be reimbursed accordingly.

With respect to the 356 days of care provided to Medicare residents requiring isolation, the Provider contends that the Medicare Intermediary Manual does not specifically address the fact pattern presented, i.e., a resident requires isolation for infection control purposes and the facility's distinct part does not have any available single rooms. Residents 1, 2, 9, 11, 14, 18, 19, 22 and 29 required isolation for infection control purposes during their stay at Facility.[3] Those residents were diagnosed as having a condition that required them to be placed in isolation. However, there was no available isolation room in the certified unit. The Provider contends it

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[1] Two other issues were originally in the appeal. One was administratively resolved subsequent to the hearing. The second was withdrawn by the Provider.

[2] Intermediary Exhibit I-10.

[3] Provider Exhibit E.

should not be required to keep these residents in a bed that is not medically appropriate just so it can be compensated for care. This would not be in the best interest of the Medicare beneficiary requiring isolation or the other Medicare recipients in the distinct part. It is also not a case in which a provider indiscriminately moved Medicare residents out of the Medicare distinct part.

These residents were placed outside the distinct part when they needed to be placed in isolation and were returned to the distinct part or were discharged when they no longer needed to be placed in isolation.

The Provider also contends that the Social Security Act allows a nursing facility to obtain relief where it, in good faith, makes an erroneous administrative decision in connection with the transfer of a person from a hospital to a skilled nursing facility. 42 U.S.C. § 1395pp(e). The Provider made a good faith but erroneous decision in placing Medicare recipients transferred from a hospital into non-certified beds due to the unavailability of beds in the distinct part. The Provider's good faith is demonstrated by the fact that facility staff was merely following the practice established by the prior owner. Good faith was also demonstrated by the fact that it discontinued the practice when informed by the Intermediary that Medicare would not pay for care rendered outside the distinct part.[4] Another indicator of the Provider's good faith is that facility staff attempted to make beds available in the Medicare distinct part by asking non-Medicare residents to move to beds outside the distinct part. It did not transfer persons who refused to move voluntarily. A skilled nursing facility cannot transfer persons who refuse a transfer outside of the certified facility (in this case, the facility is the Medicare-certified distinct part) except under certain circumstances (e.g., the resident's health has improved or the safety of other residents is impaired). 42 C.F.R. § 483.12. None of those exceptions apply to this case. The Provider witness testified that provisions of OBRA 1987 placed significant restrictions on a facility's ability to move residents without their consent.[5] As a result, Provider personnel generally could not transfer persons out of the certified part of the facility without their consent. The Provider witness also testified that there were a number of transfer agreements with area hospitals.[6] Many times beds were planned to be available but circumstances prevented bed availability, including instances where a non-Medicare resident decides not to move from the Medicare distinct part. This is not a case in which a facility carelessly or negligently placed new Medicare admissions in non-certified beds.[7] Instead, it is a case where a facility made a decision, assigning residents to beds outside the certified unit in accordance with its long-standing practice, which had never been questioned or challenged by Medicare.

The Provider points out that Medicare payment under the limitation of liability provisions of Section 1879 of the Social Security Act, 42 U.S.C. § 1395pp, provides financial relief to providers by permitting payment to be made for certain services and items for which Medicare

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[4] Provider Exhibits G and H.

[5] Tr. at 101 and 102.

[6] Tr. at 100.

[7] In addition to a legal responsibility, the witness testified Provider had a moral obligation to readmit beneficiaries that were transferred to a hospital and released for return to the Provider.

payment would otherwise be denied. HCFA Ruling 95-1, Dec. 22, 1995.[8] Medicare payment under the limitation of liability provision is dependent upon two primary factors. First, the claims for services or items furnished must have been denied for certain specific reasons, including the fact that the beneficiary was intentionally, inadvertently, or erroneously placed into a non-certified bed.

The second element in determining if Medicare payment is made under the limitation of liability provision is whether the provider knew or could reasonably have been expected to know that the items or services were excluded from coverage. To satisfy the knowledge provision under limitation of liability, a provider must show it did not know, and could not reasonably have been expected to know, that Medicare would not pay for the service or item. In determining whether a provider had prior knowledge that Medicare payment would be denied, HCFA, during the relevant time period, developed administrative presumptions, or "favorable presumptions," to be used for providers in determining whether a provider had prior knowledge that Medicare payment for services would be denied. HCFA established statistical formulas that provide a measure of a provider's accuracy in assessing whether services and items are covered by Medicare. The first formula calculates the "denial rate," which is a quarterly measurement used to indicate whether a provider can generally (defined as under 5% for SNFs) make correct judgments concerning the coverage of services and items. Denial of very few claims billed as covered is held to demonstrate a provider's ability to make correct coverage assessments under most circumstances.

The second formula calculates the demand bill "reversal rate," which quarterly measures whether a provider can generally (defined as less than 20 reversals out of 100 or fewer demand bills submitted) make correct judgments concerning the noncoverage of services or items. Like the denial rate, reversal of very few claims billed by provider as noncovered is held to demonstrate a provider's ability to generally make correct noncoverage judgements.

The Provider contends that its good reimbursement history and favorable relationship with the prior fiscal intermediary strongly supports the proposition that facility staff justifiably believed they were in complete compliance with Medicare rules and regulations. These statements are supported by the auditor's own testimony that there was no information of any problems with the Provider for the previous three years.[9] Consequently, Provider maintains that application of the favorable presumption provision is supported by the record, and accordingly, Medicare payment should be made consistent with the limitation of liability provision of the Social Security Act. The Provider also asserts that equitable principles may be considered where, as here, a skilled nursing facility accepts a Medicare recipient from a hospital and makes an erroneous administrative decision that would otherwise result in the provider being denied payment. The Provider contends that legislative grace controls in this case, even though HCFA Pub. 13-1 § 3431.3 suggests that the Provider is liable for any SNF care provided in a non-certified bed

[8] Provider Exhibit V.
[9] Tr. at 313.

unless certain conditions are met. The Provider further asserts that a statute always controls over a conflicting administrative rule or regulation. HCFA Pub. 13-1 § 3431.3 is a general rule that applies whenever a Medicare resident is placed in a non-certified bed, whereas the statutory provision is a specific rule applicable to the instant situation -- a nursing facility places a person transferred from a hospital in a non-certified bed as a result of an erroneous administrative decision. As such, the Provider contends that the equities should support the Provider's position. It provided quality care to Medicare residents and discontinued its erroneous placement practice as soon as it was notified that Medicare would not cover care in a non-certifed bed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that having no available bed in a distinct part unit is not a justifiable reason to admit a Medicare patient requiring skilled care to a non-certified bed. 42 U.S.C. § 1395i-3(a) defines a skilled nursing facility as an institution (or a distinct part of an institution) which:

1. is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care . . .
2. has in effect a transfer agreement . . .
3. meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

The requirements listed in subsections (b), (c), and (d) above include such things as: quality of life (nursing and physician requirements), resident's rights and administrative matters.

The Intermediary contends that the correct course of action was for the Provider to refuse admittance when no certified beds were available. As the facility was located in a large metropolitan area, there were many other facilities that could have served these patients.

Beds at a facility are under very strict guidelines. There are nursing staff requirements, health and safety issues and patient rights that are contingencies for a provider to participate in the Medicare program. These contingencies presuppose that a patient will be placed in a certified bed. When a facility chooses to place a Medicare patient, with a Medicare billable condition, in a non-certified bed, it assumes the liability of caring for the patient. Claiming that it admitted these patients knowing full well it did not have the certified beds available is an egregious error.

The Intermediary is not in agreement with the Provider's plea that it was unaware of the applicable law and regulations. In the Provider's final position paper its owner states in an affidavit:

> . . . it is my belief that Medicare paid the prior owner for days of care provided outside the distinct part pursuant to this practice. This compensation led staff personnel to believe that this practice resulted in fully compensable care under the Medicare program. This belief

> continued until facility received correspondence from . . . (a Medicare auditor) . . .[10]

The Intermediary contends that the Provider, whether former owner or present owner, is required to adhere to Medicare regulations. Those regulations do not state that if an invalid claim is paid by Medicare it automatically becomes a valid claim.

The Intermediary also disagrees with the Provider's attempt to utilize the limitation of liability provisions applicable to claims processing. Intermediary claims processors have no way of identifying beds as non-certified. The claim form UB-92 does not identify the bed the patient is placed in. An intermediary assumes that a provider is submitting a claim for a patient placed in a Medicare certified bed. Had this been discovered during a claims review, it would have been disallowed at that point.

The Intermediary takes exception to the Provider's assertion that this issue was first discovered in fiscal year 1994 and always allowed in prior years. First, an intermediary's audit scope and review for each provider changes from year to year. Secondly, the Intermediary notes that when this issue was discovered during the June, 1994 on-site visit, an attempt was made to review prior years. However, this was not completed because of the exit of the previous Intermediary from the Medicare program.

The Intermediary also contends that transferring a Medicare patient without an appropriate written transfer agreement is not permissible. Covering patient's rights, 42 U.S.C. § 1395i-5(c), states:

> [a] skilled nursing facility must comply with the requirement of section 1395cc(f) of this title (relating to maintaining written policies and procedures respecting advance directives).
>
> (2) Transfer and discharge rights
>
> (A) In general – A skilled facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless . . .
>
> (i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
>
> (ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
>
> (iii) the safety of individuals in the facility is endangered;
>
> (iv) the health of individuals in the facility would otherwise be endangered

In each of the above situations, the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must

[10] Provider Exhibit G.

be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician. The Provider has offered no evidence that any of the patients in question signed transfer agreements. Nor was additional evidence offered that the physician authorized the transfer.

In summary, the Provider has offered no regulation or manual instruction that permits it to allow a Medicare patient to be admitted to its facility under the auspices that it is meeting all of the requirements of the Medicare laws and regulations and to seek Medicare payment with full knowledge that it did not have a Medicare certified bed available. This, coupled with the absence of transfer agreements, leads the Intermediary to request the Board to affirm the Intermediary's adjustment disallowing days for those patients in non-certified beds.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law – 42 U.S.C.:

§ 1395pp et seq.	-	Limitation on Liability of Beneficiary where Medicare Claims are Disallowed
§ 1395i-3	-	Requirements for, and Assuring Quality of Care In, Skilled Nursing Facilities
§ 1395i-3(a)	-	Definition of Skilled Nursing Facility
§ 1395i-5(c)	-	Conditions for Coverage

2. Regulations – 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9(a)	-	Cost Related to Patient Care
§ 483.12	-	Admission, Transfer and Discharge Rights.

3. Program Instructions – Part A Intermediary Manual (HCFA Pub. 13-1):

§ 3133	-	Covered Extended Care Services

§ 3431.3	-	Application of Section 956 of P.L. 96-499 to Claims for Inpatient SNF and Hospital Services Furnished in Non-certified Beds
§ 3431.4 C	-	Provider Liability for Services in a Non-Certified Bed

4. Other:

HCFA Ruling 95-1, December 22, 1995- Medicare: Waiver of Liability

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that the Provider operated an 83 bed SNF of which 27 beds were certified for participation in the Medicare program. At issue is the disallowance of 1,311 Medicare bed days applicable to patients who were placed outside of the Medicare certified distinct part. The Board also finds that a distinct part facility is specifically certified as such, as there are comprehensive standards relating to services/quality of care rendered to Medicare beneficiaries. These standards are set forth in 42 U.S.C. § 1395i – 3.[11]

The Board notes that the Provider admitted numerous Medicare patients requiring skilled care to non-certified beds within its facility. Similarly, Medicare patients were transferred to non-certified beds when the Provider deemed it necessary for infection control purposes.

The Board finds that 42 C.F. R. § 413.9(a) states that:

> [a]ll payments to providers of services must be based on the reasonable cost of services covered under Medicare and relate to the care of beneficiaries.

In addition, HCFA Pub. 13-1 § 3133 states that custodial care is not a covered extended care service.[12] Accordingly, the Board finds that services offered to those patients not placed in a Medicare certified bed are not covered services under Medicare.

The Board is not persuaded by the Provider's argument that it is entitled to a waiver of liability for those payments which would otherwise be denied. The record indicates that the UB-92 billing form does not identify the type of bed in which the patient is placed. Thus, the Intermediary has no way of knowing that the bed was a non-Medicare bed. Therefore, the fact that the Provider may have received a favorable claims denial rate is tainted and should not be

[11] Intermediary Exhibit I-4.
[12] Intermediary Exhibit I-11.

relied on to create a "favorable presumption" that the Provider was able to make correct coverage assessments.

Additionally, HCFA Pub. 13-3 § 3431.4C indicates that the waiver of provider liability will not be made if the provider did not give timely written notice to the beneficiary of the implications of receiving care in a non-certified bed. The Board finds that the record does not contain any evidence where the Provider gave written notice to the beneficiaries regarding transfer. Nor does the record contain medical records reflecting written transfer agreements, or any evidence that physicians ever authorized the transfers from the certified to the non-certified section of the Provider facility.

The Board concludes that the law and regulations are quite clear that a provider cannot place a Medicare patient in a non-certified bed and expect to be reimbursed. Reliance on the improper, prior practices of previous owners cannot be used as a valid argument for not adhering to the Medicare requirements.

DECISION AND ORDER:

The Intermediary's adjustment to disallow days for patients in non-certified beds was correct and is affirmed.

Board Members Participating:

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

Date of Decision: September 18, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman