PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D42

PROVIDER –
Healdton Nursing Home
Healdton, Oklahoma

Provider No. 37-5262

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING-
August 6, 2002

Cost Reporting Period Ended
December 31, 1996

CASE NO. 99-0417

INDEX

ISSUE:

Was the Intermediary's methodology used in settling a low utilization cost report proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Healdton Nursing Home ("Provider") is a 68 bed skilled nursing facility located in Healdton, Oklahoma. Eight (8) of the Provider's beds are certified to participate in the Medicare program and 60 beds are not.[1]

During the Provider's cost reporting period ended December 31, 1996, the Provider received about $230,000 in Medicare reimbursement; therefore, it filed less than a full cost report based upon low Medicare utilization. Mutual of Omaha Insurance Company ("Intermediary") determined that the Provider had met the requirements for filing a low utilization cost report found at 42 C.F.R. § 413.24(h) and Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2414.4B, and HCFA Pub. 15- II § 110, and accepted the Provider's cost report submission.

In order to final settle, or determine the amount of the final retroactive adjustment of the subject cost report, the Intermediary split the Provider's general service (overhead) costs between the Medicare participating and nonparticipating routine service areas of the facility based upon patient days. No overhead allocations were made to the ancillary service areas. As a result of this methodology, the Provider's Medicare reimbursable costs were determined to be less than if the cost report had been final settled on an "as submitted" basis.[2]

On July 9, 1998, the Intermediary issued a Notice of Program Reimbursement reflecting the subject final settlement. On October 29, 1998, the Provider appealed the final settlement, or the methodology used by the Intermediary to determine the retroactive adjustment amount, to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $20,000.[3]

The Provider was represented by John C. Harned, of Baird, Kurtz & Dobson, LLP. The Intermediary was represented by Carolyn G. Manuel, Senior Consultant, Mutual Of Omaha Insurance Company.

PROVIDER'S CONTENTIONS:

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1 Intermediary Position Paper at 3.
2 Intermediary Position Paper at 4.
3 Intermediary Position Paper at Statement of Facts.

The Provider contends that its low utilization cost report, that was timely filed pursuant to Intermediary guidelines and program regulations, was in essence rejected by the Intermediary when the Intermediary attempted to compute a settlement consistent with the filing of a full cost report without obtaining the appropriate allocation statistics. The Provider asserts that the Intermediary's allocation of general service cost centers to only routine areas is inconsistent with 42 C.F.R. § 413.24(d)(1) which states, in part: "[a]ll costs of nonrevenue-producing centers are allocated to all centers that they serve. . ." Id. (Emphasis added).

The Provider acknowledges but rejects the Intermediary's argument that it was within its right to use a "routine only" allocation because this procedure had been published in a newsletter. The Provider contends that the Intermediary does not have the right to set policy that is contrary to the Medicare regulations, as this clearly is, regardless of whether or not they have made this policy public.

Regulations at 42 C.F.R. § 413.24(f)(4) explain that an intermediary is to determine whether or not a cost report is acceptable within 30 days of receipt. If a cost report is deemed unacceptable, the intermediary returns it to the provider with a letter explaining the reasons for the rejection. The regulation goes on to explain that the provider should make the necessary corrections and resubmit the cost report to the intermediary as soon as possible. Respectively, the Intermediary, in accepting the Provider's low utilization cost report indicates that :"it can determine the reasonable cost of covered services furnished beneficiaries." HCFA Pub. 15-I § 2414.4 B. In addition, certain worksheets are required to be filed with the low utilization cost report. An intermediary has some latitude to require additional information it feels is necessary to make its determination. No additional data was requested by the Intermediary in the instant case, yet the Intermediary felt the only way to determine reasonable cost was to make an allocation of cost not required by the regulations pertaining to the filing of a low utilization cost report. Notably, this is where the Intermediary advances the argument that its policy should override Medicare regulations.

By incorporating a cost allocation into the low utilization cost report, the Intermediary in essence rejects the idea that reasonable cost can be determined with less than a full cost report.

The Provider also contends that the cost allocation statistics used by the Intermediary to compute the subject settlement were inappropriate. HCFA Pub. 15-II § 3524, explains that the statistical basis found at the top of each column on Worksheet B-1 is the recommended basis. It is common to use an alternate basis, but the use of patient days as the surrogate for all of the recommended bases is not reasonable. The Intermediary did not request any data from the Provider in an effort to arrive at a reasonable cost allocation.

The Provider also rejects the Intermediary's argument that their methodology "protects the interest of the program." In response, the Provider argues that the Intermediary's procedures will consistently compute reimbursement amounts that are far lower than what is intended by the Medicare regulations. The Provider does not believe it is in the best interest of the Medicare program to pay a segment of providers less than what is due them under the law. Nor does the Provider believe this

was the intent of the provisions allowing for the filing of less than full cost reports.

In conclusion, the Provider respectfully requests that the Board allow it to submit a full cost report in response to the Intermediary's cost report adjustments and final settlement computation.[4]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it determined the amount of the Provider's final settlement in accordance with 42 C.F.R. § 405.1803, which states in part: "[u]pon receipt of a provider's cost report. . . , the intermediary must within a reasonable period of time, furnish the provider and other parties as appropriate a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider." Id. (Emphasis Added).[5]

The Intermediary explains that in order to comply with this program requirement, it established procedures which require either a desk review or an audit be performed on all cost reports whether they are filed as a low utilization cost report or a full cost report. Therefore, as part of the final settlement desk review of a less than full cost report, the Intermediary completes any additional worksheets it believes are necessary to determine whether a provider is entitled to additional payments or, conversely, whether a provider has been overpaid.

The Intermediary adds that, based upon its experience, the vast majority of less than full cost reports are submitted by providers who have been overpaid. Therefore, the Intermediary believes that a settlement determination must be processed in order to insure that providers are not receiving excessive reimbursement, and to fulfill its duties as an intermediary as defined by the Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration).
The Intermediary contends that the Provider was fully aware of the procedures that would be used to determine the final settlement of its low utilization cost report (and potential risks) and, therefore, knowingly and freely made that "election." The Intermediary explains that it established procedures for the settlement of less than full cost reports, as noted above, and has published those procedures in Medicare Newsletters which it has issued to providers since its involvement in the Medicare program. The Intermediary asserts that from the first newsletter addressing this matter (Exhibit I-11) to the most recent (Exhibit I-8), the Intermediary has made clear the procedures which are followed when settling a less than full cost report and has always cautioned providers that a sophisticated cost finding is not applied to low utilization reports and that this may negatively impact their reimbursement.

The Intermediary notes that the Provider submitted its cost report based upon the Intermediary's guidance and was, therefore, fully informed as to the implications of filing a less than full cost

report. (Exhibit I-1). Therefore, the Provider "elected" that its cost report be settled under the

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4 Provider Position Paper at 4.

5 Intermediary Position Paper at 7. Exhibit I-10.

procedures explained in the Intermediary's newsletters. Accordingly, the Provider accepted that: "the reports are processed by splitting costs into two areas: (1) routine costs; and (2) ancillary costs." Medicare Newsletter, November 1995. Clearly, the Provider accepted that: "all overhead allocations are split between the participating and nonparticipating areas based on patient days" and that "NO overhead allocations are made to the ancillary areas on a low utilization cost report." Id.

With respect to this matter, the Intermediary contends that Medicare's rules are clear that once a cost report is filed, a provider is bound by its "election." The Intermediary cites HCFA Pub. 15-1 § 2931.2.A which states in part: "a cost report filed in a manner consistent with regulations and policy governing its preparation is intended to be final when settlement has been made or following an audit when determined to be necessary by the Intermediary." Id. Further, the manual also states that: "a cost report may also be considered final when initially delivered to the intermediary although the intermediary may not have performed its desk review and, if necessary, its audit." Id.

The Intermediary asserts that there are limited circumstances under which the program will accept an amended cost report. Specifically, a provider may file or an intermediary may require an amended cost report to: (1) correct material errors detected subsequent to the filing of the original cost report; (2) comply with the health insurance policies or regulations, or (3) reflect the settlement of a contested liability. See HCFA Pub. 15-1 § 2931.2.A.[6] However, with regard to the instant case, none of these circumstances apply.

First, the Provider never sought to amend the as-filed cost report because there were no "material errors" detected subsequent to the filing. Second, the Provider did not present a contested liability that was in question at either the time of the filing or at the time of settlement. And finally, the cost report submitted complied with the requirements for filing a less than full cost report and fully complied with the health insurance policies or regulations.

The Intermediary adds that HCFA Pub. 15-1 § 2931.2.A (b) is explicit, stating: "[o]nce a cost report is filed, the provider is bound by its elections." The manual goes on to state that: "except in a situation where the provider has not complied with the health insurance policies or regulations, a provider may not file an amended cost report to avail itself of an option it did not originally elect. Id. (Emphasis added.) Notably, the Provider is asking the Board to allow it to amend its original submission by granting the right to submit a full cost report. The Intermediary does not believe that the facts and circumstances of this case allow the Board to grant the remedy that the Provider is requesting.[7]

The Intermediary rejects the Provider's argument that it acted improperly when settling the

subject cost report using the methodology defined in the Intermediary Newsletter. The Intermediary believes that the standard to be applied in this case is a "reasonability standard."

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6 Exhibit I-12

7 Intermediary Position Paper at 9.

The standard is whether the Intermediary exercised sound, reasonable, and legal discretion, or whether the Intermediary's conclusions and judgment were clearly erroneous, i.e., clearly against logic or against the reasonable and probable deductions to be drawn from the facts of this case. According to Black's Law Dictionary, abuse of discretion is defined as a "departure from reasonable use" and "being synonymous with a failure to exercise a sound, reasonable, and legal discretion." Id. It means a clearly erroneous conclusion and judgment that is against logic and the effect of such facts as are presented or against the reasonable and probable deductions to be drawn from the facts disclosed.[8]

The Intermediary believes its methodology for settling less than full cost reports meets both the requirements and the intent of the Medicare program. The regulation indicates that a provider of service may file a low utilization cost report. The Intermediary believes that the procedures spelled out in the Intermediary Newsletter are appropriate to the situation of a low utilization cost report. The regulation and manual indicate that based upon an intermediary's conclusion that it can determine the reasonable cost of covered services furnished to beneficiaries, the intermediary will advise the provider that less than a full cost report may be filed. Because the Intermediary could determine the reasonable cost based on its well-defined and long-standing policy, the Intermediary accepted and settled the subject cost report.

The Intermediary contends that Medicare's manuals define the "recommended" statistics for allocating costs on Worksheet B-1 of the Medicare cost report. Moreover, the Provider admits that it is common to use alternate statistics but argues that the use of patient days as the surrogate is neither reasonable nor logical. The Intermediary asserts, however, that patient days is the most logical statistic and the only one supported by the facts and circumstances in this case. In the absence of a full cost report, and submission of supporting documentation for cost allocation statistics, the only statistic readily available to the Intermediary is the patient days statistic. Because the Intermediary must maintain a provider billing record, which includes Medicare patient days, and because the Provider submits the Worksheet S series, which includes total patient days, this statistic is the one available to the Intermediary and is easily verifiable and has been documented. The Intermediary argues that to use any other statistic would not be reasonable because the documentation submitted with a less than full cost report does not support other statistics.[9]

The Intermediary acknowledges the Provider's argument that the use of patient days as the sole allocation statistic has a negative effect on its reimbursement.[10] Moreover, the Intermediary

agrees that not allocating costs to the ancillary cost centers reduces the amount of the Provider's reimbursement. However, the Intermediary argues that it is not responsible for "maximizing" Medicare reimbursement for providers of service. The Intermediary asserts that it has published

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8 Intermediary Position Paper at 10.
9 Intermediary Position Paper at 11.
10 Id.

its procedures for settling a less than full cost report. Furthermore, it has explicitly cautioned providers that because a sophisticated cost finding is not applied to low utilization reports, it may be in their interest to file a complete report in those instances where Medicare's dollar involvement is material to a facility.

The Intermediary notes that calculations using the statistical bases from the Provider's subsequent year cost report would net the Provider nineteen thousand seven hundred and six dollars more than using just patient days. (Exhibit I-9) On the other hand, however, the program would have overpaid the Provider forty-four thousand two hundred and eighty-six dollars if the cost report had been settled as-filed. Accordingly, the Intermediary believes that a reasonable standard was applied when the cost report was settled using patient days as the cost allocation statistic. Further, the Intermediary does not believe that material harm has been done to the Provider by using this reasonable and logical approach of cost allocation based on patient days. The Provider was fully apprised that not applying a sophisticated cost finding could impact the amount of its Medicare reimbursement.

Finally, the Intermediary rejects the Provider's argument that it was not allowed the opportunity to submit information to allocate costs.[11] The Intermediary believes it did not abuse its discretion when a request was not made for the Provider to document cost allocation statistics. The Intermediary had documented the methodology for settling less than full cost reports. The Provider was apprised of the fact that the patient days statistic would be used for cost allocation and the Intermediary followed the published procedures. There was no need to ask for additional support. In addition, program regulations and manuals require the Intermediary to make an "up-front" decision as to whether a settlement can be issued based upon a less than full cost report. In the instant case, the Intermediary issued a final settlement based upon its published procedures and used the basis that is supported by the situation created by the filing of a low utilization cost report.

In summary, the Intermediary contends that it followed the requirements of the program when the final settlement was issued. The Intermediary has a long-established procedure for settling less than full cost reports that is reasonable and logical and meets the requirements of the Medicare program. The Provider made a fully informed and free election to file a less than full cost report. The Provider does not meet the circumstances defined by the program for filing an amended cost report. Accordingly, the program manuals do not support the remedy requested by the Provider and the Provider must be held to the elections from its original filing.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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[11] Intermediary Position Paper at12.

§ 405.1803	-	Intermediary Determination and Notice of Amount of Program Reimbursement
§ § 405.1835-.1841	-	Board Jurisdiction
§ 413.24 et seq.	-	Adequate Cost Data and Cost Finding

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

§ 2414.4 B	-	Conditions Under Which Less Than a Full Cost Report May Be Filed
§ 2931.2 et seq.	-	Reopening Final Determination

3. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

§ 110	-	Conditions Under Which Less Than a Full Cost Report May Be Filed

4. Other :

Black's Law Dictionary.

Intermediary Medicare Newsletter, November 1995.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Regulations at 42 C.F.R. § 413.24(h) allow providers that furnish a low volume of Medicare services to submit less than a full Medicare cost report if certain conditions are met. In pertinent part, the regulations state:

> [i]f the provider has had low utilization of covered services by Medicare beneficiaries (as determined by the intermediary) . . .the intermediary may waive a full cost report . . . if it [the intermediary] decides that it can determine, without a full or simplified report, the reasonable cost of covered services . . . .

42 C.F.R. § 413.24(h).

Program instructions at HCFA Pub. 15-1 § 2414.4. B, entitled Low Medicare Utilization, go on to state:

> [u]nder this situation, the intermediary will require that the provider furnish all of the following information using program forms: (1) page one of the applicable cost report form, (2) the officer certification sheet, (3) the balance sheet, (4) the statement of income and expense and (5) other financial and statistical data the intermediary may deem appropriate depending upon the circumstances in the individual case.

HCFA Pub. 15-1 § 2414.4. B.

The Intermediary, relying upon these program rules and instructions issued a newsletter to the Medicare providers it serviced. The newsletter, dated November 1995, and entitled Filing of Short-Form Cost Reports, defines low utilization as Medicare reimbursement of less than $350,000. Most significantly, however, with respect to the instant case, the newsletter describes the methodology the Intermediary will use to process and final settle low utilization cost reports. In pertinent part the Intermediary states:

> [a] desk review is performed on all reports filed as a low utilization cost report. The reports are processed by splitting costs into two areas: (1) routine costs; and (2) ancillary costs. All overhead allocations are split between the participating and nonparticipating areas based on patient days. No overhead allocations are made to the ancillary areas on a low utilization cost report.

Intermediary Newsletter, November 1995 (emphasis added).

On May 27, 1997, the Provider filed a low utilization cost report with the Intermediary. The Provider indicated that it had received Intermediary approval to file less than a full cost report on May 22, 1996, and that it had received less than $350,000 in Medicare reimbursement as required. Subsequently, thereafter, on July 9, 1998, the Intermediary issued a final settlement of the Provider's cost report. The settlement reflected the calculation of the Provider's program reimbursement using the methodology contained in the Intermediary's newsletter. This means that the Provider's overhead costs were split between the Medicare program and other payers using "patient days" as the sole allocation statistic and that no overhead costs were allocated to the Provider's ancillary cost centers.

On October 29, 1998, the Provider appealed the Intermediary's calculation of its cost report settlement. The Provider explains that allocating overhead costs on the basis of patient days

generally understates a provider's reimbursable costs as opposed to a more sophisticated basis of allocation. The Provider also notes that the Intermediary was free to request data to allocate costs on a more equitable basis than solely upon "patient days," but it did not do so.

The Provider asserts, in general, that the Intermediary's determination is improper because it employed an overhead cost allocation methodology that was inconsistent with 413.24(d)(1), which states in part that: "[a]ll costs of nonrevenue-producing centers are allocated to all centers they serve. . . .," which is not the case with the Intermediary's methodology, for it failed to allocate overhead to the ancillary cost centers.

The Provider argues that the Intermediary, in accepting a low utilization cost report does so because it believes "that it can determine, without a full or simplified report, the reasonable cost of covered services . . . . 42 C.F.R. § 413.24(h). By making an allocation of cost not required by the regulations pertaining to the filing of a low utilization cost report, the Intermediary in essence rejects the idea that reasonable cost can be determined with less than a full cost report.

The Provider believes it should be permitted to submit an amended cost report in order to have its final settlement calculated on the basis of a full cost report.

The Board finds that 42 C.F.R. § 413.24(h), as quoted above, allows the Intermediary to use its discretion in determining the reasonable cost of Medicare covered services. The regulation does not prescribe or restrict any particular methods or procedures to be used in this process. Rather, the rule provides only that the Intermediary decide whether or not it can determine the reasonable cost of covered services without a full cost report. The fact that the Intermediary incorporated some type of cost allocation into its cost determination is irrelevant; assuming that is, that the allocation is logical and produces reasonably sound results. Notably, there is no evidence in the record showing that the Intermediary's determination of allowable program costs is unreasonable, although it is understood that a more sophisticated method of cost finding would produce a different result.

The Board also rejects the Provider's argument that the Intermediary's failure to allocate costs to the ancillary cost centers is inconsistent with 42 C.F.R. § 413.24(d)(1), which requires the allocation of overhead costs to all cost centers that they serve. The Board finds this rule applicable to providers that are preparing full cost reports for submission to intermediaries. It is not applicable, however, to an intermediary determining reasonable costs in situations where a provider requests and is granted low utilization status and where less than a full cost report is

submitted.

Finally, the Board finds that the Provider was clearly aware of the Intermediary's policies pertaining to the approval and final settlement of low utilization cost reports. Accordingly, the Provider made an informed choice subject to program instructions at HCFA Pub. 15-1 § 2931.2 A , which state in part: "[o]nce a cost report is filed, the provider is bound by its elections . . . . a provider may not file an amended cost report to avail itself of an option it did not originally

elect. Id.[12] Accordingly, the Provider's desire to file an amended cost report in this instance is inappropriate.

DECISION AND ORDER:

The methodology used by the Intermediary to final settle the Provider's low Medicare utilization cost report was proper. The Intermediary's settlement is affirmed.

Board Members Participating:

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

Date of Decision – September 19, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

[12] The Board acknowledges limited circumstances where the program will accept an amended cost report. HCFA Pub. 15-1 § 2931.2 A. The Board notes, however, that none of those circumstances are present in the instant case.