PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D31

PROVIDER –
University Hospital
Cincinnati, OH

Provider No. 36-0003

vs.

INTERMEDIARY –
AdminaStar Federal, Inc.

DATE OF HEARING -
March 19, 2003

Cost Reporting Periods Ended -
June 30, 1994, 1995 and 1996

CASE Nos. 98-0507
99-2398
00-0946

INDEX

ISSUES:

1: Was the Intermediary's reclassification of certain administrative costs from ambulatory service areas to the Administrative and General Cost Center proper? (Fiscal years 1994, 1995, and 1996).

2: Was the Intermediary's reclassification of clinic dieticians' salary costs to the Dietary Cost Center proper? (Fiscal years 1994 and 1995).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University Hospital ("Provider") is a 619-bed, general short-term care facility located in Cincinnati, Ohio. During the Medicare cost reporting periods ended June 30, 1994, 1995 and 1996, the Provider incurred certain administrative costs which it believes should be directly charged to various ambulatory service cost centers for the purpose of determining Medicare reimbursement. AdminaStar Federal, Inc. ("Intermediary") disagreed with the Provider and required that these costs be classified or charged to the Administrative and General Cost Center ("A&G") and "stepped-down" through the Medicare cost report process for the purpose of determining Medicare reimbursement.[1]

In addition, during the Medicare cost reporting periods ended June 30, 1994 and 1995, the Provider incurred certain clinical dieticians' costs which it charged directly to various ambulatory patient care areas to determine Medicare reimbursement. The Intermediary, however, reclassified these costs to the Dietary Cost Center where they were also stepped-down for the purpose of Medicare cost finding.

The Provider appealed these issues 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 approximate amount of Medicare funds in controversy is as follows:

				Amount in Controversy	
Case Number	Fiscal Year	NPR Date	Appeal Date	Issue #1	Issue #2
98-0507	1994	6/30/97	12/23/97	$273,282	$13,000
99-2398	1995	9/30/98	3/25/99	$229,710	$19,343
00-0946	1996	6/30/99	12/23/99	$211,036	NA

The Provider was represented by Peter L. Cassady, Esq., of Beckman, Weil, Shepardson and Faller, LLC. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

[1] In 1994, the Provider charged these costs to the subject outpatient cost centers and the Intermediary perfected cost report adjustments reclassifying them back to A&G. In 1995 and 1996, the Provider itself charged these costs to A&G in accordance with Medicare rules regarding prior years' adjustments, but identified them as protested amounts in order to establish appeal rights.

Issue 1- Administrative Salaries and Fringe Benefits
Background

The Provider accumulated the salaries, fringe benefits, and "other costs" (computer supplies, stationery, etc.) of certain outpatient administrators in two of its cost centers: Ambulatory Services Administration (Cost Center No. 4170) and Outpatient Registration (Cost Center No. 4010). The Provider believes the costs charged to Cost Center No. 4170 should be directly charged to various ambulatory service areas for the purpose of Medicare cost finding based upon time estimates furnished by the individuals involved. The Provider contends that the "other costs" at issue should be directly charged to the ambulatory service areas based upon actual invoices. The Provider asserts that costs included in Cost Center No. 4010 should be directly charged to those areas by applying the ratio of clinic visits to total clinical visits. The Provider believes the Intermediary's decision to classify all of these costs as A&G expenses is because the Provider did not have time studies for each of the involved employees. The Provider generally argues that the Intermediary's decision results in a portion of these costs being inappropriately allocated to inpatient services.[2]

PROVIDER'S CONTENTIONS:

The Provider contends that it directly charged these exact same costs to ambulatory service areas in many prior cost reporting periods and the Intermediary did not reclassify them to A&G in those periods. The Provider asserts that these same classifications where made in its prospective payment system base year with Intermediary approval.[3]

The Provider contends that the salaries and salary related expenses included in Cost Center 4170 pertain to specific employee categories. Apportionments from this cost center for the purpose of Medicare cost finding can be made based upon the employees' estimates of the amount of time they spend working on behalf of outpatient services (Exhibit P-2). Other direct expenses (non-salary expenses) included in Cost Center No. 4170 include computer supplies, stationery, brochures and publications, furnishings, equipment repair, other equipment, and rental equipment. These expenses are determined from actual invoices generated by the individual ambulatory clinics (Exhibit P-3).

The Provider contends that the costs included in Cost Center No. 4010 were incurred by employees who work only in that cost center (outpatient admitting). Therefore, it is unreasonable to require time studies to support their direct charge to the ambulatory service areas.

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[2] Provider Position Paper at 3. NOTE: All footnotes to Provider and Intermediary Position Papers refer to Case Number 98-0507. Although the Position Papers for Case Number 98-0507 pertain to fiscal year 1994, the arguments and contentions contained therein are essentially identical to those presented for each of the other cost reporting periods at issue.

[3] Provider Position Paper at 3.

Overall, the Provider contends that the subject costs have nothing to do with inpatient services. Therefore, the Intermediary's decision to classify them to A&G is improper because it results in some of these costs being inappropriately allocated to inpatient service areas and significantly reduces Medicare reimbursement. The Provider contends that the Intermediary's classification is unreasonable because it is based solely upon the fact that the Provider lacks employee time studies.

The Provider disputes the Intermediary's argument that it is selectively choosing to directly charge only those costs that will enhance its Medicare reimbursement. The Provider maintains that it is accounting for the subject costs to reflect reality; that is, that they were incurred to provide ambulatory services.

The Provider also rejects the Intermediary's argument that it is violating program instructions contained in Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) § 2313.1. The Provider asserts that it has not created new cost centers on the Medicare cost report but simply chooses to classify costs applicable to outpatient activities in the appropriate cost centers. The Provider also asserts that it is unreasonable to suggest that it needed to submit a written request to make such classifications since it had already made them without Intermediary objection for many years.[4]

Finally, the Provider rejects the Intermediary's argument that it has made no attempt to be consistent and classify costs that are exclusively inpatient costs to inpatient service areas. The Provider argues that the only costs that are 100 percent inpatient are routine service costs and special care unit costs. Since inpatients use ancillary services, it is reasonable to allocate costs such as those charged to Inpatient Accounts and Inpatient Business Office, as noted by the Intermediary, to A&G for cost allocation and apportionment.[5]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider established a unique cost center, Ambulatory Services Administration, without approval. Therefore, there is no assurance that the subject cost center and the method of allocation adopted for that cost center results in a more accurate method of cost finding as required by program instructions at HCFA Pub. 15-1 § 2313.1. Rather, the Intermediary asserts that the Provider has selectively chosen to direct-cost service areas that will enhance its Medicare reimbursement while ignoring to direct-cost service areas that may be detrimental to its Medicare reimbursement. [6]

The Intermediary cites HCFA Pub. 15-1 § 2313.1. D, as follows:

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[4] Provider Letter, August 1, 2002.

[5] Id.

[6] Intermediary's Revised Position Paper at 5.

> [a] written request [to use a unique cost center] must be submitted to the intermediary 90 days prior to the end of the cost reporting period for which it applies and must be approved by the intermediary within 60 days from the date of receipt. The intermediary's approval, which applies to both the cost centers and the proposed basis of allocation, must be furnished in writing and is binding for the initially approved and all subsequent cost reporting periods until a subsequent request is approved.

HCFA Pub. 15-1 § 2313.1.

The Intermediary explains that the Provider never made a request to establish a unique cost center. Moreover, employee time estimates and number of clinic visits are not accurate, auditable, allocation bases. Also, the Provider's A&G account includes the Inpatient Accounts and Inpatient Business Accounts cost centers that appear to be 100 percent inpatient expenses. However, the Provider made no attempt to direct-cost these expenses.

With respect to the Provider's use of employee time estimates as an allocation base and the inability to audit this data, the Intermediary cites HCFA Pub. 15-1 § 2304, Adequacy of Cost Information, as follows:

> [c]ost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, . . . bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited.

HCFA Pub. 15-1 § 2304 (emphasis added).

The Intermediary notes that 42 C.F.R. § 413.24 also requires providers of service receiving payments on the basis of reasonable cost to provide adequate cost data "capable of verification by qualified auditors."

The Intermediary also contends that the Provider has furnished no evidence that clinic visits is an accurate method of allocating costs. The Intermediary cites Butler Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 88-D8, December 16, 1987, Medicare & Medicaid Guide (CCH) ¶ 36,798, aff'd, CMS Administrator, February 16, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,002, finding that the provider did not prove with auditable data from its records that it meets the requirements of 42 C.F.R. § 405.453(a) and (c). Further, the Board found that "the provider had not proven either that its methodology was more accurate, as required by 42 C.F.R. § 405.453(d)(2)(ii), or that the results were more accurate." Id.

Moreover, the Intermediary cites The Brooklyn Hospital v. Schweiker, 596 F. Supp. 326, (E.D.N.Y. 1984) finding that "alternative methods of allocating administrative and general costs are available to a

provider that is able to demonstrate that the alternatives yield a more accurate method of cost allocation, but only if all of the provider's A&G costs are similarly treated . . . . The regulations and manual provisions permit providers to choose between either using a general accounting method for all costs or formulating a more accurate method of calculating all administrative costs, but not removing only the one cost for which the provider stands to gain by the use of an alternative method of cost finding."

Finally, the Intermediary asserts that direct costing certain expenses to outpatient areas while continuing to allocate through step-down other costs that may pertain only to inpatient services inappropriately shifts costs to the Medicare program in violation of 42 C.F.R. § 413.5.

Issue 2 - Clinic Dieticians' Salary Costs
Background

The Provider charged the salaries and fringe benefits of its clinic dieticians to various ambulatory patient care areas using estimates of the time the involved employees spend working for those areas. The Intermediary reclassified these costs back to the Dietary Cost Center where they were stepped-down to both inpatient and outpatient services for the purpose of Medicare cost finding. The Provider explains that the Intermediary's adjustments were prompted by the fact that the Provider did not have time studies to support its classifications.

PROVIDER'S CONTENTIONS:

The Provider admits that it does not have time studies for the involved employees.[7] The Provider argues, however, that it never had time studies for these employees in prior cost reporting periods but the Intermediary allowed these cost classifications. The Provider notes that the Intermediary first made this adjustment in its fiscal year 1992 cost report. The Provider asserts, therefore, that it is not being reimbursed for these costs through Medicare's prospective payment system and it will not receive any Medicare reimbursement for these expenses if the Intermediary's classification is upheld.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider was unable to provide auditable documentation such as time studies to support the allocation of the subject costs to the various cost centers at issue. Therefore, the Intermediary reversed the Provider's classifications due to a lack of documentation in accordance with 42 C.F.R. § 413.24.

The Intermediary contends that it made this same adjustment in the Provider's fiscal year 1992 cost report, thus putting the Provider on notice that it needed documentation in order to claim this allocation.

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[7] Provider Position Paper at 6.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue 1- Administrative Salaries and Fringe Benefits:

There are three parts to this issue which need to be addressed. It must be determined whether or not certain administrative salaries and benefit costs should be directly charged to the Provider's ambulatory service areas or be included in the Provider's A&G cost center and allocated to both inpatient and outpatient services. In addition, the same determination must be made for certain "other costs" (e.g., computer supplies and stationary), and the costs of the Provider's Outpatient Registration services (outpatient admitting). The Board notes that the Provider charged the administrative salaries and benefit costs at issue in this case to its ambulatory service areas based upon employee time estimates, "other costs," based upon actual invoices, and outpatient admitting based upon the ratio of clinic visits to total clinical visits. The administrative costs at issue, both salary costs and "other costs" pertain to Account No. 4170 in the Provider's accounting records; Outpatient Registration pertains to Account No. 4010.

Neither party provided an overwhelming amount of evidence in support of its position. Additional information such as employee job descriptions and time studies would have been helpful to support the Provider's claim regarding administrative salary costs. Similarly, the Intermediary could have furnished more substantive data regarding its claim that the Provider was selectively choosing to "direct-cost" only those items or services that enhance its Medicare reimbursement. Accordingly, some level of subjectivity is required in the Board's analysis of these issues.

With respect to the administrative salaries and related benefits portion of this matter, the Board understands from the record that the pertinent Provider employees function as managers of the various ambulatory service areas at issue. Therefore, the Board finds that the Provider's method of charging these individuals' costs directly to those service areas for which they are responsible is a more accurate method of cost finding than charging their costs to A&G and allocating them to both inpatient and outpatient operations as required by the Intermediary. Accordingly, the Board finds the Intermediary's classification of these costs is improper.

With respect to the "other costs" at issue, the Board finds that the Intermediary did not challenge the propriety of the Provider's use of actual invoices to charge these expenses to the subject ambulatory service areas. The Board concludes, therefore, that the Intermediary's classification of these costs is also improper. The Provider's decision to directly charge these expenses to the subject ambulatory service cost centers along with the managers' salaries and benefits discussed immediately above results in a more accurate method of cost finding than that required by the Intermediary.

With respect to the last part of this issue, the Board finds the Provider's position improper; that is, Outpatient Registration costs should not be directly charged to the Provider's ambulatory service areas. In effect, the Board finds the benefits realized from the Provider's outpatient admitting activities to be essentially the same as the benefits realized from its inpatient admitting activities. Accordingly, these costs should be treated in the same manner for the purpose of Medicare cost finding. This "equal" treatment can be accomplished by directly charging outpatient admitting costs to outpatient departments while directly charging inpatient admitting costs to inpatient departments or, as required by the Intermediary, by charging both costs to A&G and letting them flow through the cost report process. The Board notes program instructions at HCFA Pub. 15-1 § 2313.2.A.

As mentioned above, the Board acknowledges the Intermediary's argument that the Provider is selectively choosing to direct charge only those items or cost centers that increase its Medicare reimbursement. However, the Intermediary furnished no evidence in support of this argument. While the Intermediary noted two cost centers it purports benefits only inpatient services, it furnished no evidence in support of this claim.

Finally, the Board acknowledges but rejects the argument that the Provider failed to obtain Intermediary approval to change the allocation base of the subject costs, i.e., from the basis of accumulated cost used to allocate A&G costs through Medicare's step-down process to the direct charge types of bases at issue. In part, the Board finds that accuracy of the Medicare cost finding process can outweigh the substance of a formal request. Moreover, there is evidence in the record showing that the Intermediary, in several previous cost reporting periods, had allowed the Provider to directly charge the administrative costs at issue without objection.

Issue 2 - Clinic Dieticians' Salary Costs:

The Provider asserts that certain dieticians' costs should be directly charged to various ambulatory service areas based upon employee time estimates. The Intermediary required these costs to be classified within the Provider's Dietary Cost Center (Account No. 4046) where they were stepped-down through Medicare's cost finding process to both inpatient and outpatient areas. The Intermediary's position is prompted by the fact that the Provider did not have time studies to support its position.

The Board's analysis of this issue shows that the Provider's documentation is, in fact, the key matter to be addressed. The Provider acknowledges that it does not have time studies to support the direct charging of the involved individuals' salary costs. Moreover, no job descriptions or similar evidence was introduced into the record to help support the Provider's claim. Accordingly, without documentation to support the Provider's argument, the Board concludes that the Intermediary's position is proper; the subject costs should be included in the Provider's dietary cost center.

DECISIONS AND ORDERS:

Issue 1- Administrative Salaries and Fringe Benefits

The Provider's direct charging of administrative salaries, related fringe benefit costs, and certain "other costs" from Account No. 4170 to various ambulatory service areas is a more accurate method of cost finding than the methodology required by the Intermediary. The Intermediary's adjustment or required classification of these expenses is reversed. The Provider's direct charging of Outpatient Registration or admitting costs from Account No. 4010 is not consistent with Medicare's cost finding practices and is improper. The Intermediary's adjustment or required classification of these expenses is affirmed.

Issue 2 - Clinic Dieticians' Salary Costs

The Intermediary's adjustment or required classification of the Provider's clinic dieticians' costs is proper. The Intermediary's position is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.

Date: May 15, 2003

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman