PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D39

PROVIDER –
Angeles Home Health Care, Inc.
Los Angeles, California

Provider No. 05-7252

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC-CA

DATE OF HEARING –
December 5, 2003

Cost Reporting Periods Ended
July 31, 1994 and
July 31, 1995

CASE NOS. 96-0591 and 97-2042

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ISSUE:

Should denied Medicare visits be included in the "total visits" count for purposes of apportioning costs to the Medicare program?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Angeles Home Health Care, Inc. (Provider) is a Medicare certified home health agency located in Los Angeles, California. During its Medicare cost reporting periods ended July 31, 1994 and July 31, 1995, the Provider was reimbursed based upon a "cost per visit" determined through the Medicare cost report process. In general, the Provider's direct and indirect costs were grouped to determine the total cost of each discipline of service the Provider furnished, e.g., skilled nursing care, physical therapy, and speech therapy. The total cost of each discipline was then divided by the total number of visits made for that service (i.e., the total of both Medicare and other or non-Medicare patient visits) to determine the cost per visit per discipline. The Provider's cost per visit was then multiplied times the number of Medicare visits made in each discipline to apportion costs to the Medicare program and determine program reimbursement.

Blue Cross of California (Intermediary) reviewed the Provider's cost reports and found the Provider had claimed a greater number of Medicare visits than the number shown on the Provider Statistical and Reimbursement Report (PS&R).[1] The difference was determined to be visits the Provider had made to Medicare beneficiaries for which payment had been denied. To address this matter the Intermediary adjusted (reduced) the Medicare visits shown on the Provider's cost reports to agree with the PS&R and reclassified the denied Medicare visits to the Provider's "other visits." Since these adjustments did not change the "total visits," the Provider's program reimbursement was reduced, as its costs per visit remained unchanged while its Medicare visits decreased.[2]

The Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $88,104 ($34,280 in 1994 and $53,824 in 1995).[3]

The Provider was represented by Mark S. Kennedy, Esq. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

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[1] Blue Cross of California was subsequently replaced by United Government Services as the Provider's intermediary.

[2] The Provider claimed 85,790 Medicare visits in its 1994 cost report. The Intermediary found that 310 of these visits had been "denied" by the Medicare program. The Intermediary reclassified these visits to the "Other" visits category. For 1995, the Provider claimed 110,317 Medicare visits. Here the Intermediary found that 640 visits had been "denied," and reclassified them to "Other" visits.

[3] Intermediary's Position Paper at 2. Provider's Post-Hearing Brief at 13.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

PARTIES' CONTENTIONS:

At issue in this case is whether Medicare home health visits performed by the Provider but denied for reimbursement should be included in the Provider's "total visits" when determining Provider's average cost per visit. 42 C.F.R. §413.53(a)(3). The Intermediary believes the visits should be excluded from Medicare visits but included in total visits, which by nature of the methodology, reduces the Provider's program reimbursement. The Provider asserts, however, that denied Medicare visits should be eliminated from the cost report all together.

The Provider argues that under Medicare rules only those visits that can be billed to the party reasonably expected to pay are to be included in the cost report calculations. The Provider asserts that if Medicare determines that a visit cannot be reimbursed, the Provider cannot bill the patient or any other insurer. Accordingly, the cost of the visit becomes a general cost of doing business and is properly accounted for by eliminating the visit from the cost report. According to the Provider, this approach proportionately distributes the denied service costs to all payors, while the Intermediary's approach distributes Medicare costs to non-Medicare patients in opposition to Medicare's cross-subsidization rule. 42 U.S.C. §1395x(v)(1)(A).

The Intermediary argues that Medicare made a distinct determination that it would not pay for the subject visits; therefore, it is essential that they remain in the Provider's total visit statistics. The Intermediary explains that if denied Medicare visits are removed from total visits, it causes the Provider's average cost per visit to increase and the Provider to be reimbursed for a portion of the cost associated with denied visits.

FINDINGS OF FACTS, CONCLUSIONS OF LAW AND DISCUSSION:

42 C.F.R. §409.48(c) states that it is not necessary for an episode of personal contact with a patient to be reimbursable in order to be judged a "visit"; rather, it only requires that the reason for the episode be for the purpose of providing a covered service. Notably, the Provider does not dispute that the subject visits were performed to furnish a covered service, but only that Medicare would not pay for them due to a lack of medical necessity determination.

Having concluded that the program recognizes visits even though payment has been denied, 42 C.F.R. §413.53(a)(3) requires that they be included in the Provider's total visit statistics. In pertinent part, the regulation states:

> *Cost per visit by type-of-service method*—HHAs. For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. (emphasis added).

Application of these rules in the instant case is essentially the same as the Board's findings in Maxicare, Inc. v. Blue Cross Blue Shield Association/Palmetto Government Benefit Administrators, PRRB Case No. 2000-D55, May 30, 2000, decl'd rev., CMS Admin., July 18, 2000 (Maxicare). In Maxicare, program payments for home health visits were denied because the visits were performed outside of a physician's plan of treatment. Nonetheless, the Board found that "visits" were performed according to the definition at 42 C.F.R. §409.48(c), and that they must be included in the provider's total visit statistics according to 42 C.F.R. §413.53(a)(3).

The Board agrees with the Intermediary's representation that excluding denied Medicare visits from total visits would result in the Provider being partially reimbursed for visits which were not entitled to be reimbursed by Medicare.

DECISION AND ORDER:

The Intermediary properly included denied Medicare visits in the Provider's total visit statistics for the purpose of apportioning costs to the Medicare program. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq. (Recused)
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West

DATE: September 16, 2004

FOR THE BOARD:

Dr. Gary B. Blodgett
Board Member