PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D71

PROVIDER -
Logos Healthcare Rehabilitation, Inc.
Boone, NC

Provider No.: 34-6538

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 00-3350

INDEX

ISSUES:[1]

1. Was the Intermediary's adjustment to Medicare bad debts proper? (Provider Issue 1)
2. Were the Intermediary's adjustments to salaries – administrative proper? (Provider Issue 2)
3. Was the Intermediary's adjustment to salaries – physical therapy proper? (Provider Issue 2)
4. Was the Intermediary's adjustment to salaries – speech therapy proper? (Provider Issue 2)
5. Was the Intermediary's adjustment to salaries – occupational therapy proper? (Provider Issue 2)
6. Was the Intermediary's adjustment to other charges – physical therapy proper? (Provider Issue 3)
7. Was the Intermediary's adjustment to other charges – speech therapy proper? (Provider Issue 3)
8. Was the Intermediary's adjustment to other charges – occupational therapy proper? (Provider Issue 3)
9. Was the Provider's request for additional costs for depreciation proper? (Provider Issue 4 and Intermediary Issue 17 in Initial Position Paper)

MEDICARE STATUTORY AND REGULATORY BACKGROUND

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

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. 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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 to determine the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R.

[1] The issue numbers in the Intermediary and Provider position papers are not the same. For simplicity, this decision utilizes the issue numbers 1-8 from the Intermediary's supplemental position paper and notes the corresponding issue number in the Provider's position paper in parentheses. Issue 9, concerning depreciation, is addressed in the Provider's supplemental position paper as issue 4 on page 14 and in the Intermediary's initial position paper as issue 17 on page 18.

§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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Logos Healthcare Rehabilitation, Inc. (the Provider) was a privately owned, for-profit, outpatient rehabilitation facility located in Boone, North Carolina. The Provider was one of three Medicare-certified facilities in the PTK Management, Inc. (PTK) chain of healthcare facilities. The Provider furnished outpatient physical, speech, and occupational therapy services to Medicare patients in various nursing homes. The Provider claimed costs for its services on its fiscal year ended December 31, 1996 cost report and also included home office costs allocated from PTK.

The Provider terminated from the Medicare program on April 30, 1999. The Provider's fiscal intermediary at the time of its termination was Blue Cross Blue Shield of North Carolina.[2] The Intermediary entered into an inter-plan agreement with First Coast Service Options, Inc. (First Coast) to perform the outstanding audits on all Logos facilities. First Coast made the audit adjustments at issue in this case in a Notice of Program Reimbursement (NPR) issued on June 27, 2000. The Provider timely appealed the adjustments to the Board and has met the jurisdictional requirements of 42 C.F.R. §405.1831-405.1841. The amount of Medicare reimbursement for all issues is approximately $3,068,755. Intermediary's Supplemental Position Paper at 1.

The Board held a hearing for this case on November 7, 2001. Because of concerns raised at the hearing, the Board suspended the proceedings and agreed to the Provider's request to make its decision on this case on the written record. Tr. at 11. Because so many of the Intermediary's adjustments were due to lack of documentation and the Provider contended that a full review of its documentation had not occurred, the Board requested that the Intermediary perform additional audit work. The Board allowed the Provider to submit additional documentation. At the Board's request, the Intermediary reviewed the additional documentation and on January 30, 2003, submitted a report and proposed post-audit adjustments. Exhibit I-4.

To facilitate consideration of the case on the record, the Board asked the Intermediary to submit a supplemental position paper that addressed, for any costs disallowed after the re-audit: 1) why the audit adjustment was made; 2) what additional documentation the Provider submitted; and 3) why the additional documentation was not sufficient to reverse the adjustment. After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a brief in response to the Intermediary's revised positions and to submit to the Board documentation necessary to support its position.

[2] Currently, Cahaba Safeguard Administrators, LLC is the Program Safeguard Contractor and Palmetto Government Benefits Administrators is the Intermediary. All three entities will be referred to as the Intermediary.

The Intermediary submitted its supplemental position paper on March 30, 2005. The Provider did not submit anything further. The record hearing was held on June 10, 2005.

The Provider was represented by Thomas William Baker, Esquire, of Troutman Sanders LLP. The Intermediary was represented by Eileen Bradley, Esquire, and Bernard Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue 1. Was the Intermediary's adjustment to Medicare bad debts proper?

FACTS:

The Intermediary disallowed the Provider's bad debts for lack of documentation. The Board requested that the Provider submit additional documentation and that the Intermediary review the documentation. After the review, the Intermediary continued to deny the costs. The amount of Medicare reimbursement at issue is approximately $208,688.

PARTIES' CONTENTIONS:

The Provider states that it provided a list of its bad debts with its original cost report. The Provider asserts that the Intermediary failed to review the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

The Intermediary states the Provider only submitted documentation pertaining to certain patients and that documentation was incomplete. Intermediary's Supplemental Position Paper at 8. The Intermediary did not propose any revision to its initial adjustment. See Id. at Exhibit I-6 at 2-3.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There was no evidence in the record to determine whether the Provider had sufficient documentation to support its bad debt claims. The Board finds that without proper documentation, the Provider's claim for bad debts is not supported, and the Intermediary's adjustment was proper.

Issues 2-5. Were the Intermediary's adjustments to salaries – administrative, physical therapy, speech therapy and occupational therapy proper?

FACTS:

The Intermediary disallowed the Provider's claimed salaries for administrative, physical therapy, speech therapy and occupational therapy due to lack of documentation. The Board requested that the Provider submit additional documentation and that the

Intermediary review the documentation. After the review, the Intermediary continued to deny the salaries because the Provider did not submit any additional documentation. Intermediary's Supplemental Position Paper at 8-10.

PARTIES' CONTENTIONS:

The Provider asserts that in order to audit salaries, the Intermediary is required to test the Provider's payroll system, use the employee's earning register to verify salaries and request and review appropriate documentation. The Provider claims that the Intermediary requested copies of W-2s/1099s, contracts, employee job titles and the number of hours each employee worked in order to verify total paid salaries. However, the Intermediary disallowed the claimed salaries, citing a lack of documentation. The Intermediary also claims that the Provider failed to provide requested W-2s, and that the salaries on the 1099 and 941 forms did not reconcile to salaries claimed on the as-filed cost report. The Provider asserts that the 1099s and 941s cannot be reconciled with the cost report because the cost report salaries are stated on the accrual basis of accounting, whereas the 1099 and 941 forms report salaries on the cash basis of accounting. The Provider contends that while not in the form of W-2s, it furnished to the Intermediary all information necessary to substantiate salaries.

The Intermediary indicates that the Provider did not submit any additional information for review and therefore, the Intermediary continues to maintain that the documentation is insufficient to allow additional costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The salaries were accumulated at the Provider's home office, allocated to the Provider and claimed on the Provider's cost report. The Board finds that the Provider's failure to submit W-2s or 941s is not determinative. Rather, the real issue revolves around what services the employees provided and to which entity in the chain of providers. The Board finds that the Provider failed to submit payroll records, contracts or other verifiable documentation to prove that the costs were related to patient care and to support the basis for the allocation of costs from the home office to the Provider. The Provider merely presented a grouping of expenses but no documentation to support the allocation. Exhibit P-2(b). The Board does not believe that the documentation requested by the Intermediary, i.e., W-2s and 941s would, in itself, necessarily be sufficient to support the allocation of these costs even if it had been furnished. Instead, the Provider should have provided a detailed accounting of the allowable services and associated hours provided by the employees to each provider in support of the allocation. Absent this detailed documentation, the Intermediary's disallowance of these costs was proper.

Issue 6-8. Were the Intermediary's adjustments to physical, speech and occupational charges proper?

FACTS:

The Intermediary made adjustments to reconcile Medicare therapy charges per the as-filed cost report to the Provider Statistical and Reimbursement Report (PS&R). Since total therapy charges come from the Provider's records and are not impacted by this reconciliation, decreases in Medicare charges precipitate an increase in "other charges."

Other charges usually represent denied claims for therapy services. After its review of additional documentation furnished by the Provider, the Intermediary did not revise its original adjustment. The amount of Medicare reimbursement at issue is approximately $392,593.

PARTIES' CONTENTIONS:

The Provider disagrees with the Intermediary's increase of the Provider's non-Medicare charges. The Provider claims that non-Medicare charges were not listed on the PS&R and that it maintained financial logs to record all charges. The Provider asserts that these logs were available to the Intermediary during the audit and that the Intermediary did not make a written request for this information. The Provider contends that the adjustments were made without any basis and should be reversed.

The Intermediary made adjustments to reconcile the Medicare charges and other charges to agree with the PS&R and to reconcile to total charges. The Intermediary reiterated its offer to review any additional records furnished by the Provider.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary offered to review the Provider's records to determine whether the adjustments for charges should be reversed. However, there is nothing in the record to indicate that the Provider made those records available to the Intermediary. In addition, the record does not contain the Provider's financial logs. Without any documentation to support the Provider's claim, the Board finds that the Intermediary's adjustments to reconcile the Medicare charges and other charges to agree with the PS&R were proper.

Issue 9. Was the Provider's request for additional costs for depreciation proper?

The Provider did not claim the correct depreciation expense in its cost report. The Intermediary stated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the correct depreciation allowed. Intermediary's Initial Position Paper at 18.

PARTIES' CONTENTIONS:

The Provider claims that during the 1992 audit, which was completed in 1995, the Intermediary developed a depreciation schedule for the Provider. The Provider states this schedule was developed after it submitted cost reports for fiscal years 1993 through 1995. The Provider asserts that the Intermediary should have relied upon prior year audit workpapers and corrected the depreciation expense for the year under appeal.

The Intermediary stated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board notes that the Intermediary stated that it would review the previously approved depreciation schedule and allow the appropriate depreciation expenses. The Board remands this matter to the Intermediary to determine the appropriate depreciation expenses.

DECISIONS AND ORDERS:

Issue 1. Medicare Bad Debts

The Board finds that the Provider did not supply documentation to support its claim for bad debts. The Intermediary's adjustment for lack of documentation is affirmed.

Issues 2-5. Salaries – Administrative, Physical Therapy, Speech Therapy and Occupational Therapy

The Board finds that the Provider did not provide documentation to support the allocation of salaries. The Intermediary's adjustments disallowing salaries are affirmed.

Issues 6-8. Other Charges –Physical, Speech and Occupational Therapy

The Board finds that the Provider did not provide any documentation to support its claim. The Intermediary adjustments are affirmed.

Issue 9. Additional Costs for Depreciation

The Board remands the depreciation issue to the Intermediary to review the previously approved depreciation schedule and allow the appropriate depreciation expenses.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: September 19, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman