PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D65

PROVIDER -
Senior's Home Health Care, Ltd.
Chicago, Illinois

Provider No. 14-7472

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Health Care Service Corporation

DATE OF HEARING-
May 13, 1998

Cost Reporting Periods Ended -
December 31, 1992 and
December 31, 1993

CASE NOs. 96-1352 & 96-1353

INDEX

ISSUE:

Was the Intermediary's adjustment to disallow legal fees deemed not related to patient care proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Senior's Home Health Care Ltd. ("Provider") is a freestanding, proprietary home health agency located in Chicago, Illinois. The Provider was certified to participate in the Medicare program on November 5, 1987. The Provider furnishes the following services: skilled nursing, physical therapy, speech therapy, occupational therapy, medical social services and home health aide services. The Provider started its operations on April 16, 1987, by assuming a branch operation of a certified home health agency that was bankrupt and had terminated participation in the Medicare program on April 15, 1987. The Provider continued to serve the prior home health agency's patients based upon their attorney's recommendation that the services they furnished would be covered by the Medicare program. However, the Provider was not certified for program participation until November 5, 1987.

Since the Provider was not certified for Medicare participation until November 5, 1987, all claims for visits prior to that date were denied by Health Care Service Corporation ("Intermediary"). Also, costs incurred during the period before November 5, 1987 could not be considered start-up costs because start-up costs are those costs incurred by a provider until the first patient is seen. Since the Provider assumed the operations of another HHA, the first patient was seen the first day of operations; there were no start-up costs.

The Provider sued their former attorney for malpractice due to the incorrect information that they could be paid for patient visits before they were certified by the Medicare Program. The Provider engaged a law firm to represent them in a malpractice suit against their former legal counsel. The Malpractice suit alleged negligence in the services rendered which caused severe financial loses to the Provider. The malpractice suit was comprised of three components of services:

The establishment of a homemaker cost center
Related party interest
The delivery of care to Medicare beneficiaries prior to Medicare certification

On November 20, 1995 the Provider received a revised Notice of Program Reimbursement from its Intermediary. The Intermediary adjusted the Provider's cost report to reflect an adjustment to disallow legal fees deemed not related to patient care. The Provider disagreed with the Intermediary's adjustment and filed a timely appeal with 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 Medicare reimbursement is approximately $18,000 for 1992 and $27,376 for 1993.

The Provider was represented by William R. Giammaruti, Esquire of Davis, Pinel & Associates. The Intermediary was represented by Bernard M. Talbert, Esquire of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues that the legal fees associated with the malpractice suit are normal operating costs and were necessary and proper costs. The Provider argues that the legal fees were directly related to the care of Medicare beneficiaries and were a reasonable and necessary cost of operations. This is in accordance with the Medicare regulation at 42 C.F.R. § 413.9(b)(2) which states in part:

> Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

Id.

The Provider points out that the intent of this regulation is to ensure that a provider has the flexibility to address issues and situations that effect agency operations. The malpractice suit relates directly to the financial losses incurred by the Provider in rendering care to Medicare beneficiaries and from its participation in the Medicare cost finding and cost apportionment process. Therefore, the legal fees are a cost of operations associated with the rendering of patient care.

The Provider points out that it maintains it's accounting records on the accrual basis of accounting. This method is prescribed in 42 C.F.R. § 413.24(a)(2) and states in part:

> Under the accrual basis of accounting, revenue is reported in the period in which it is earned, regardless of when it is collected; and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Id.

The legal fees were incurred in FYE 12-31-93. According to the above regulation, the legal fees are considered a current expense and properly reported in FYE 12-31-93.

The Provider points out that the Financial Accounting Standards Board (FASB) defines an expense as one that is associated with the ongoing operations of the entity. Specifically, FASB Statement of Concepts 6, Paragraph 80 states:

> Expenses are outflows or other using up assets or incurrances of liabilities (or

> combination of both) from delivering or producing goods, rendering services, or carrying out other activities that constitute the entity's on going major or central operations.

Id.

The FASB further recognizes that expenses are considered current period activity when related to an entity's ongoing operations. (FASB Statement of Concepts 5, Paragraph 85.). Therefore, according to Medicare regulations and FASB, the Provider followed proper accounting procedures in recognizing the legal fees as a current year expense.

The Provider contends that legal fees are related to patient care and are therefore allowable. The Provider points out that HCFA Pub. 15-1 at § 2183 addresses the allowability of legal fees as follows:

> Legal fees and related costs incurred by a provider are allowable if related to the provider's furnishing of patient care, e.g. legal fees incurred in appeals to the Provider Reimbursement Review Board and, if applicable, further appeals subsequent to a Board decision. . .

Id.

This program instruction specifically cites PRRB appeals as an event for which legal fees are allowable. The legal fees for a PRRB appeal are an allowable expense regardless of the reimbursement topic at issue. In the case of the Provider's malpractice suit, two distinct reimbursement topics are at issue. The reimbursement topics at issue relate to the furnishing of services to Medicare beneficiaries and the Medicare cost reimbursement process. Therefore, the legal fees are an allowable expense in accordance with the above mentioned Program instruction.

The Provider contends that the cost finding process is directly related to patient care. It is fundamental that the determination of costs related to patient care is designed to insure that costs that are attributable to the provision of care to Medicare beneficiaries is reimbursed by the Medicare program. Any action taken by a provider to ensure the proper cost apportionment to the various types of services rendered is the direct result of the cost finding process. Since the financial loss could not have occurred until after the completion of the cost report which occurs after the end of the Provider's fiscal year end, the cost finding process is related to patient care. The incorrect advice given to the Provider by its attorneys at the time resulted in a financial loss to the Provider.

The Provider argues that part of its financial losses were the result of lost Medicare reimbursement from the disallowance of related party interest. The owner of the Provider loaned money to the Provider for working capital purposes under the incorrect advice that the

interest payments on the loan agreement would be reimbursed by the Medicare program. However, in accordance with Program instructions, the interest on the loan was not reimbursed by the Medicare program. The Provider contends that if it had been properly advised of the Medicare implications related to the issue, alternative financing arrangements would have been made and the interest would have been an allowable expense.

The Provider argues that the legal fees it incurred as a result of the malpractice suit are related to patient care. The Provider rendered services to Medicare patients but its claims were denied. The financial loses and the ensuing malpractice suit are directly related to the rendering of care to Medicare patients. Therefore, the denial of claims for Medicare beneficiaries is a reimbursement issue. There is no basis to designate the legal fees as non-allowable because Medicare denied payment on the claims. The Provider points out that a similar case would be the legal fees associated with a hearing before an Administrative Law Judge for denial of Medicare claims. The legal fees in this case would be allowable regardless of whether the claims were overturned.

The Provider contends that the out of court settlement with the Provider's former attorneys should not be treated as a recovery of cost. According to HCFA Pub. 15-1 § 810.1

> [p]unitive damages, i.e., those damages specifically designated punitive damages by the court, are not treated as reductions of costs. Amounts received which are related to cost periods prior to the provider's participation in the program and which have not been reflected in allowable costs under Medicare are not treated as reductions of costs. The settlement was based entirely on the damages that occurred as a result of lost Medicare reimbursement. There was no recovery of legal fees as a part of the settlement.

Id.

The Provider argues that the distribution of the out of court settlement has no relevance in determining the allowance of the legal fees. There is no relationship between the out of court settlement and the legal fees.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the lawsuit pertains to a time period which is not covered by Medicare certification. The Intermediary points out that 42 C.F.R. § 413.9 states in part:

> (a) Principle. All payments to providers of services must be based on reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

> (b) Definitions - (1) Reasonable cost-- Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

Id.

The Intermediary also point out that HCFA Pub. 15-1 § 2100 also states that: "All payments to providers of services must be based on the reasonable cost of services covered under Title XVIII of the Act. . ." Id. As the legal fees were not covered under program regulations or instructions, then costs associated with that period are not reimbursable.

The Intermediary points out that according to HCFA Pub. 15-1 § 2105.4, costs incurred representing unsuccessful beneficiary appeals are not allowable, but costs pertaining to successful appeals are allowable. Following that thought, the legal fees pertaining to the time period for which the claims were not paid are not allowable.

The Intermediary contends that the settlement received by the Provider from the malpractice law suit should be treated as a recovery of cost. According to HCFA Pub. 15-1 § 810.1 "[m]onetary damages received by a provider as a result of a court decision, settlement, legal action or other claim for damages, are considered reductions of cost if they represent recoveries of previously allowed costs." Id. The Intermediary points out that the Provider had been reimbursed for their legal fees for the FYE 12-31-92 and 12-31-93.

The Intermediary argues that the legal fees should be offset against cost because the owner of the Provider received $48,500 of the $123,500 settlement. This represented a settlement for personal damages suffered by the owner of the Provider. Therefore, the legal fees associated with the owners claim should not be reimbursed by the Medicare program.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 413.9 et. seq.	-	Cost Related to Patient Care

§ 413.24(a)(2)	-	Adequate Cost Data and Cost Finding

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

§ 810.1	-	Reduction of Cost Through Court Decision, Settlement or Other Legal Action
§ 2100	-	Principle
§ 2105.4	-	Costs of Unsuccessful Beneficiary Appeal
§ 2183	-	Legal Fees and Other Related Costs

4. Other:

Financial Accounting Standards Board (FASB) Concept 6, § 80.

Financial Accounting Standards Board (FASB) Concept 5, 85.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the controlling laws, regulations and program instructions, the facts of the case, parties' contentions and evidence in the record finds that the Intermediary's disallowance of the Provider's legal expense was proper. The legal costs were directly related to the litigation of the malpractice suit for actions that occurred when the Provider was not a certified Medicare provider. The Provider's legal costs are not related to care of its patients and therefore are not allowable costs under the provisions of 42 C.F.R. § 413.9.

The Board finds that the legal fees pertain to a time period which is not covered by Medicare certification. The Provider incurred the legal fees for a malpractice suit for the period prior to its being certified as a Medicare provider. The Board points out that the regulation at 42 C.F.R.
§ 413.9 states in part: "[a]ll payments to providers of services must be based on reasonable costs of services covered under Medicare and related to the care of beneficiaries." (Emphasis added).
Therefore the Board concludes that since the malpractice event occurred when the Provider was not certified to participate in the Medicare program, the legal expense incurred in the malpractice suit was not a Medicare cost.

The purpose of the malpractice litigation was to resolve whether the Provider's attorney acted improperly in informing the Provider that it would be paid for its cost of operations by the Medicare program prior to its being certified as a Medicare provider and that the cost of interest expense arising from a loan from the owner of the Provider would be an allowable cost. The Provider's legal costs are not related to patient care and therefore are not allowable costs.

The Board also notes that in this case the interest claimed as an expense from a related party is not an allowable Medicare cost. Although the Provider was informed by its former attorney that the interest was an allowable cost, the Provider through its malpractice suit was reimbursed for these costs. However, they were never allowable Medicare costs.

The Board notes that the record is unclear as to whether the Intermediary offset the settlement amount against the Provider's administrative and general (A&G) cost. The Board finds however, that the Intermediary's contention that the amount of the malpractice settlement should be offset against the Provider's A&G cost is without foundation. Since the legal costs were not allowable, the amount of the settlement is for a period when the Provider was not participating in the Medicare program and therefore the settlement amount should not be offset against the Provider's A&G costs.

DECISION AND ORDER:

The Provider's costs incurred for legal services in relation to the malpractice suit are not costs related to patient care and are, therefore, not allowable Medicare costs. The Intermediary's adjustments are affirmed.

The Provider's settlement income in relation to the malpractice suit should not be offset against the Provider's A&G costs. Although the record was unclear as to whether the Intermediary actually offset the settlement income, that amount should not be offset.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: June 18, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman