PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D55

PROVIDER –
Pleasant Care – Parkview
Bakersfield, CA

Provider No. 55-5336

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
September 25, 2002

Cost Reporting Period Ended
March 31, 1999

CASE NO. 01-2262

INDEX

ISSUES:

1. Was the Intermediary's adjustment to advertising costs proper?
2. Were the Intermediary's adjustments reclassifying Medical Director cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pleasant Care - Parkview ("Provider") is a 184-bed Medicare Skilled Nursing Facility ("SNF") located in Bakersfield, California. Mutual of Omaha Insurance Company ("Intermediary") audited the Provider's cost report for the period ended March 31, 1999 and adjusted the Provider's claimed cost of advertising and Medical Director's cost for utilization review ("UR").

The Intermediary issued a Notice of Program Reimbursement ("NPR") on August 31, 2000, in which an adjustment was made to reduce advertising costs by $4,741. In addition, the Intermediary adjusted the Medical Director's costs of $250 and $6,710.[1] The effect of these adjustments was to reduce the amount of Medicare reimbursement due the Provider. The Provider disagreed with the Intermediary adjustments and timely appealed the NPR to the Provider Reimbursement Review Board ("Board"). The Provider's filing met the jurisdictional requirements in accordance with the Medicare regulations at 42 C.F.R. §§ 405.1835-.1841. The Medicare effect of the adjustments is approximately $11,120.

On Worksheet E, Part, line 18 of the as-filed cost report, the Provider claimed $250 as direct Medicare reimbursement for the UR duties of the Medical Director. Via adjustment number 13, the Intermediary eliminated the $250 from reimbursement stating UR duties are routine in nature. The Provider also claimed $6,710 of Medical Director's fees in the Nursing Facility cost center. Via adjustment number 10, which was posted to Worksheet A-6, the Intermediary reclassified this cost to the A&G cost center.

The Provider was represented at the hearing by Paul Gulbrandson, CPA. The Intermediary was represented by Thomas Bruce, CPA and Matt Pleggenkuhle, Cost Report Appeals Consultant, of the Mutual of Omaha Insurance Company.

[1] During the hearing the parties appear to have been confused about how the Medical Director's fees were claimed on the as-filed cost report and how the adjustments were actually made. The Provider's witness testified that: "[t]he issue was created when the Intermediary removed utilization review costs from direct reimbursement on cost report Worksheet E, Part 1, and added the cost back to the administrative and general cost center via Worksheet A-8 . . ." Tr. at 138:5-14. Throughout the hearing both the Provider and the Intermediary characterize the adjustments as if they had both been made to utilization review costs that were claimed as direct Medicare costs and reclassified by the Intermediary to the administrative and general ("A&G") cost center. Neither party attempted to clarify the issue as being for Medical Director's fees that were claimed differently on the as-filed cost report, adjusted separately by the Intermediary for different reasons, and effectuated in different ways. Consequently, the record on this issue remains confused.

ISSUE 1 - ADVERTISING COSTS:

PROVIDER'S CONTENTIONS:

The Provider contends that the advertising costs were legitimate and proper costs of delivering patient care to Medicare beneficiaries. The Provider notes that the Board has heard similar cases and found similar advertising costs to be allowable and that the Medicare regulations do not prohibit advertising as an allowable expense. The Provider maintains that the Intermediary's audit adjustment was based on speculation and conjecture and did not consider the available facts. It asserts that the Intermediary is bound by certain rules of audit procedure and audit technique, commonly referred to in the industry as the "Yellow Book."[2]

The Provider also argues that the Intermediary's efforts to obtain evidence sufficient to support the proposed audit adjustment were overly burdensome. The Provider's witness claims that the Intermediary's auditors had the opportunity to review such records if they came to the Provider's office. Provider also claims that the Intermediary did not make a request for records until one month prior to the scheduled hearing.[3]

The Provider also urged the Board to disregard part of the Intermediary's evidence. The Intermediary work papers reflected that an employee of the Provider admitted in a telephone interview with the Intermediary's desk auditor that the advertising costs were for an unallowable expense. The Provider asserts that the employee was not an appropriate representative and that his purported comment that the advertising was for patient solicitation should not be considered credible evidence.[4]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not documented with sufficient supporting evidence that the advertising expense claimed was an allowable cost. The Intermediary points out that the Medicare regulations make it the responsibility of the Provider to furnish support for the allowability of the claimed expense.[5] The evidence presented by the Provider was inadequate to show the nature of the claimed expense and the Provider failed to respond to the Intermediary's repeated written and telephone requests for additional documentation.[6] Moreover, during the desk review by an Intermediary auditor, the auditor conducted a telephone interview with an employee of the Provider's home office who stated that the advertising expense was "used for advertising for soliciting of patients,"[7] an unallowable expense.

In response to the Provider's claim that the Intermediary was required to conduct an audit at the Provider's office to comply with the "Yellow Book," the Intermediary points out that the Provider failed

---

[2] Government Auditing Standards.
[3] Tr. at 38:17-39:23.
[4] See Exhibit I-2.
[5] Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. 42 C.F.R. § 413.24.
[6] Tr. at 28:10-32:17.
[7] See Exhibit I-3, PRRB Case No. 99-2359 and Tr. at 30:24-32:10.

to make any specific reference to procedures or techniques it claims were violated. The Intermediary conducted a desk audit.

ISSUE 2 – MEDICAL DIRECTOR COSTS:

PROVIDER'S CONTENTIONS:

The Provider contends that the Medical Director costs in dispute were in fact related to the Utilization Review Process and were therefore properly categorized as filed. The Provider also contends that Utilization Review is a Medicare only process.[8] The Provider also made the following contentions:

a. The Intermediary did not submit one iota of documentation with the related NPRs.
b. The Intermediary actually performed an audit, but did not perform it properly.[9]
c. The Provider does not have to prove allowability until the Intermediary looks at the Provider's documentation.
d. The Intermediary's requests for documentation were too burdensome.[10]
e. It is more economical for the Provider to travel to Baltimore than to have photocopies of relevant documentation for two facilities.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not establish the allowability of the UR expense as a direct cost on the Medicare Settlement Worksheet in accordance with the cost reporting instructions at CMS Pub. 15-II §§ 3519 and 3534.1. These instructions specify that:

> [I]f the utilization review extends to more than the Medicare patients, but the records of the physician activities are not satisfactory for allocation purposes, then apportion the utilization review physician service among all patients using the SNF.

The Intermediary points out that the Provider did not adequately document direct cost treatment, and that it is the Provider's responsibility to furnish support for the direct cost treatment of the claimed expense. 42 C.F.R. § 413.24(a) states in relevant part that "[p]roviders receiving payment on the basis of reasonable cost must provide adequate cost data." Since the Provider was unable to provide the documentation necessary to demonstrate the allowability of the expense, the Intermediary argues that it properly adjusted the expense.

[8] Tr. at 13:1 and Tr. at 131:14 thru 146:20.
[9] Tr. at 148:25 and 158:8 –158:18.
[10] Tr. at 150:1-152:4.

The Intermediary points out that it attempted to obtain the source documentation from the Provider to substantiate the allowability of the claimed expense. It requested additional information by letter, including follow up letters, by discovery, and by telephone. However, the Intermediary never received the information.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, parties' contentions and evidence presented, finds and concludes that the adjustments made by the Intermediary to the Medical Director fees (UR cost) and the advertising cost are proper.

This case involves two issues, the common theme of which is the Provider's responsibility to properly document its costs. The Provider has taken the position that the Intermediary did not come to the Provider's facility to perform an on-site audit and, therefore, the Provider does not have the responsibility of proving that its claimed costs are allowable. The Provider's witness testified that "the way an audit works is the cost report is filed, the Intermediary comes in and the Intermediary looks at the documentation to prove that it is not allowable. The Provider doesn't have to prove it's allowable."[11]

Advertising Costs:

The Provider's reliance on the "Yellow Book" in support of its position is misplaced. The audit guidelines do not shift the burden of proof to the Intermediary. The Board finds that the Provider was not in compliance with the Medicare regulation at 42 C.F.R. § 413.24 - Adequate Cost Data and Cost Finding. That regulation states in part:

> (a) Providers receiving payment on the basis of reimbursable cost must provide adequate cost data.
>
> * * * * *
>
> (c) Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. . . .

With regard to advertising costs, the Board finds that the Provider was informed by the Intermediary that it was the Provider's responsibility to maintain proper documentation. During the hearing the Provider's witness was asked to read an excerpt from a letter the Intermediary had written in response to a proposal the Provider had made a regarding Provider's advertising costs. The Intermediary stated that, "it is not acceptable for medical (sic) purposes to allow an arbitrary amount of advertising costs, i.e. $5,000,

[11] Tr. at 133.

which has not been specifically supported. You will need to provide specific support for each facility for the advertising expense claimed, which were not for patient solicitation."[12]

Based on the evidence submitted and the above mentioned testimony, the Board concludes that the Provider did not furnish sufficient documentation to support its position.

The Board finds that the Intermediary made several attempts to obtain the necessary documentation. This was done prior to the finalization of the NPR as well as shortly before the hearing. The Provider did not respond and did not present documentation at the hearing to support its position.

Medical Director Fees and UR Costs:

The Provider's witness, employed as the Provider's Director of Reimbursement,[13] testified that "it was his understanding" that utilization review by medical personnel was conducted only for Medicare patients.[14] He represented that the records requested would have been "burdensome" to copy and send to the Intermediary but that if the Intermediary had come to the Provider's facility to audit, they would have been furnished at least a sample of records to support the Provider's position. He also acknowledged that the Intermediary indicated that a sampling might be sufficient. However, when the Intermediary did not get back to him to specify records for a sampling, the Provider did not furnish any documentation whatsoever of utilization review records to the Intermediary[15] nor did the Provider furnish any support to the Board for its position. We also note the Provider witness's correspondence to the Intermediary in which he stated: "Unfortunately, I must admit that some of the facilities do not keep complete records of UR meetings."[16]

Because the Provider failed to furnish relevant records to support its position, the Board concludes that the Intermediary's adjustment was proper.[17]

DECISION AND ORDER:

Advertising Costs:

The Intermediary's adjustment to the Provider's advertising cost was proper due to a lack of documentation. The Intermediary's adjustment is affirmed.

---

[12] Tr. at 156.
[13] Tr. at 37:18.
[14] Tr. at 145:10-146:20.
[15] Tr. at 150:1-154:1.
[16] Tr. at 155:24-156:9.
[17] As discussed in footnote number 1, neither party presented evidence or testimony at the hearing to clarify precisely how the cost for the Medical Director's fees was claimed nor how it was adjusted. Nevertheless, the Board's conclusion that there was a lack of documentation to support the claimed cost is not impacted by the confusion surrounding these costs.

Medical Director\Costs:

The Intermediary's adjustment of the Provider's Medical Director's cost (UR) was proper due to a lack of documentation. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Gary D. Blodgett, DDS
Martin W. Hoover, Jr., Esq.

DATE: August 28, 2003

FOR THE BOARD:

Suzanne Cochran
Chairperson