PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D24

PROVIDER –
Pleasant Care Corporation - California

Provider No. Various

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
February 4, 2003

Cost Reporting Period Ended
Various

CASE Nos. 98-0362G, 99-2356, 01-0053

INDEX

ISSUE:

Was the Intermediary's adjustment to deny the allocation of social service costs based on departmental gross charges proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statues and Regulations:

This dispute arises out of the Intermediary's failure to reimburse the Providers the amount they claim is due on a reasonable cost basis under the Medicare program of the Social Security Act 42 U.S.C. §§ 1395 et seq., for the 1997 and 1998 fiscal years.

In order to participate in the Medicare program, a hospital must file a provider agreement with the Secretary - 42 U.S.C. § 1395cc. The Secretary's 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 the Medicare law and under interpretative 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 what proportion of those costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 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 NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Background:

Pleasant Care Corporation owns and serves as the home office to the 14 free-standing skilled nursing facilities (the "Providers") disputing the Intermediary's decision.[1] Pleasant Care Corporation and the Providers are part of a for-profit chain located almost entirely in California. The group Providers originally filed cost reports for various fiscal years (ending between 08/31/1995 and 05/31/1996) with the Social Service cost allocation basis of time spent. Although the Medicare cost reports indicated "time spent" as the social service cost center allocation statistic, the statistic actually used was "nursing hours." The two individual Providers originally filed cost reports with all Social Service expense classified in the Administrative and General cost center, thus allocating such expense on the basis of accumulated costs.

[1] Twelve Providers are part of group case 98-0362G, two Providers appealed under individual cases.

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D24

PROVIDER –
Pleasant Care Corporation - California

Provider No. Various

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING -
February 4, 2003

Cost Reporting Period Ended
Various

CASE Nos. 98-0362G, 99-2356, 01-0053

INDEX

Subsequent to the original filing, the group Providers requested a change in the allocation statistic, to which the Intermediary responded on December 6, 1996, with a denial of such change, unless the Providers could demonstrate that a statistic other than "time spent" would have resulted in a more accurate allocation. Following the denial of the Providers' requests, the Providers filed amended as-filed cost reports with the Social Service costs being allocated on gross departmental charges. In response to the amended cost reports, on January 23, 1997, the Intermediary rejected them with a specific denial of the Providers' change in Social Service cost allocation basis to gross revenues.

The Providers then filed amended as-filed cost reports with the original Social Service cost allocation intact. However, the Providers added a Protested Amount on the settlement worksheet for the difference between the amount that would be reimbursed with the originally filed statistic (nursing hours) and the desired statistic (gross departmental charges). In response to this set of amended cost reports, the Intermediary accepted them, and upon the subsequent issuance of the NPR, adjusted to remove the Protested Amounts in accordance with the cost reporting instructions.

The group and individual Providers filed appeals to protest these NPRs to the Provider Reimbursement Review Board ("Board"). The Providers' filings meet the jurisdictional requirements of 42 C.F.R. §405.1835-.1841. Paul R. Gulbrandson, Medicare Provider Appeals Consultant, represented the Provider. Matt Pleggenkuhle, of the Mutual of Omaha Insurance Company represented the Intermediary. The amount of Medicare reimbursement in dispute is approximately $269,000.

PROVIDER'S CONTENTIONS:

The Providers contend that the allocation basis of gross departmental charges is more accurate than the recommended basis of time spent, the alternative basis of patient days and the as-filed basis of nursing hours.

The Providers contend that the allocation of Social Service costs, based upon gross departmental charges ensures a proper allocation in accordance with the applicable statutory and regulatory authority. The Act at section 1861(v)(1)(A) states,

> "Such regulations shall (i) take into account both direct and indirect costs of providers of services … in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs."

The Provider notes that the concept of reasonable costs includes indirect as well as direct costs and the bearing of proportional costs between Medicare beneficiaries and other patients is resounded at 42 C.F.R. §413.9. This regulation further states that "It is the intent of Medicare that payments to providers of services should be fair to the providers…"

The Providers contend that they are required to follow the uniform accounting and reporting system of the Office of Statewide Health Planning and Development (OSHPD) of the State of California and that this system requires the classification of Social Service costs in the "support service" cost center, not under the routine or ancillary cost centers.

The Providers contend that a "current year" time study analysis[2]supports a 25% allocation to the routine cost centers and a 75% allocation to the Administrative and General and Ancillary cost centers. Further, Providers assert that they have supplied sufficient data and information to support the basis for their request.

The Providers' witness testified that this time study was not intended to comply with the provisions set forth in the Provider Reimbursement Manual (CMS Publication 15-I, §2313.2(E)), but instead was an analysis designed for the purpose of indicating the function of the Social Service personnel. From this analysis, the witness maintained that the Providers were able to determine that the Social Service personnel functions were "more under the A&G instead of the routine service cost center." As a result, the Provider does not argue that the statistics should be based upon the analysis, but instead that the Social Service costs be allocated on accumulated costs or gross departmental charges to ensure a more accurate reflection of the services provided by the Social Service personnel.[3]

The Providers contend that Medicare patients experience a shorter length of stay than non-Medicare patients, and thus the amount of Social Service rendered to them is more intense than that rendered to patients staying in the non-Medicare area. Therefore, the allocation of Social Service costs exclusively to the routine cost centers provides an inequitable and excessive allocation to the patients staying in the non-Medicare area.

Finally, the Providers contend that the Intermediary has failed to substantiate any reasonable cause not to grant the Providers' request.

INTERMEDIARY'S CONTENTIONS:

[2] Providers Exhibit at P-3 (Case No. 98-0362G).
[3] Transcript ("Tr.") at 53-61.

The Intermediary contends that the Providers have not adequately documented that the Social Services functions performed were furnished to any cost centers other than routine. In accordance with 42 C.F.R. §413.24(d)(1),[4] the costs of Social Service, a non-revenue producing cost center, should not be allocated to the ancillary cost centers for which there is no evidence of benefits received from the Social Service department. The Providers have not documented that the ancillary departments receive such benefit from the Social Service department.

The Intermediary contends that medical social services are routine in nature and should not be allocated to ancillary cost centers in accordance with program rules. In part, program instructions at CMS Publication 15-I, §2203.1[5] state:

> "to reduce the potential impact of unusual or inconsistent charging practices, the following types of items and services, in addition to room, dietary, medical social services, and psychiatric social services, are always considered routine in an SNF for purposes of Medicare cost apportionment…"

The Providers' job description for the Director of Social Services shows that the primary purpose of the position is to plan, organize, develop and direct the operations of the Social Services department. The Providers' organizational chart reflects the clear separation of the Social Services director from the Administration department. Based upon the documentation in the record,[6] the functions performed by the Social Services department are clearly routine in nature.

The Intermediary contends that the accounting system used by the Providers, as required by the OSHPD, does not override the Medicare cost reporting instructions. The Intermediary notes that the Providers' witness is in agreement that state level accounting policy does not override Medicare cost reporting instruction and further that the time study or analysis referred to as the primary evidence was not approved by the Fiscal Intermediary nor sanctioned by the State of California.

The Intermediary contends that the Providers have not adequately documented that gross departmental charges and/or accumulated costs provide a more accurate allocation basis for Social Service costs. The primary support furnished by the Providers to substantiate the claim that time spent is not an appropriate basis of allocation for Social Service costs is a time study or time analysis capturing the statistic of time spent.

The time study is not in accordance with the program rules at CMS Publication 15-I, §2313.2[7] as the Provider did not request Intermediary approval, did not adhere to

---

[4] Intermediary's Exhibit at I-5 (Case No. 01-0053).
[5] Intermediary's Exhibit at I-6 (Case No. 01-0053).
[6] Provider's Exhibit at P-1 (Case No. 98-0362G) includes the Organizational Chart and the Job Description.
[7] Intermediary's Exhibit at I-8(d) (Case No. 01-0053).

the recommended minimum data capture periods, and the time period studied was not contemporaneous with the costs to be allocated.

The Intermediary acknowledges the possibility that the Social Service costs may have included admitting services that may be properly included in the Administrative and General cost center. The Intermediary further acknowledges that where the Provider can identify or split out the admitting costs, such costs could be reclassified in the Administrative and General cost center. However, the Intermediary points out that while some costs within the Social Service cost center may actually relate to the admitting function, sufficient and contemporaneous evidence must be furnished by the Provider to support the classification of any such cost to the Administrative and General cost center. No such evidence exists in the record.

The Intermediary contends that, due to the absence of adequate supporting documentation for a change from the recommended allocation basis of time spent, that the basis of patient days is the appropriate allocation statistic. Additionally, for all cost reports under this appeal, the Social Service cost should be formally classified in the Social Service cost center and allocated to the routine cost centers on the basis of patient days.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the evidence presented and the parties' contentions, including the Provider's post-hearing brief, finds and concludes that the Intermediary properly refused to permit the Providers to use gross departmental charges or accumulated costs as the allocation basis for Social Service costs.

The Board finds that the Provider did not present adequate documentation to properly allocate Social Service costs on a basis other than patient days. The Medicare regulation at 42 C.F.R. §413.24(a) requires: "Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based upon their financial and statistical records which must be capable of verification by qualified auditors." The Medicare regulation at 42 C.F.R. §413.24(d) describes the cost finding methodology, including the step-down method of allocating non-revenue generating cost centers to all cost centers they serve.

The program instructions at CMS Publication 15-I, §2313 and cost reporting forms at CMS Publication 15-II, §3590 provide the recommended and acceptable cost centers and cost allocation statistics for implementation of the step-down methodology. The Board finds that the Providers' allocation did not adhere to the aforementioned regulations and program instructions by failing to adequately document services rendered and by failing to meet the criteria required for periodic time studies.

The Providers submitted a time study summary for only one Provider, for less than one month, which was not contemporaneous with the cost reporting period under appeal. Additionally, no source data was furnished to support the summary, and the Providers' witness was unable to explain any details of how the document was produced. For example, he could not say what source information was used or by whom the data was collected. Although four persons were identified by the Providers as performing social services activities, the person whose name appears on the study was not among the four identified.

The Board finds that there is insufficient documentation in the record to establish that the Providers' methodologies resulted in a more accurate allocation basis. Additionally, there is no evidence in the record to support the Provider's position that members of the Social Service department furnished services to the ancillary departments.

DECISION AND ORDER:

The Intermediary's refusal to change the Social Service cost allocation basis to gross departmental charges or accumulated costs was proper.

BOARD MEMBERS PARTICIPATING:

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

Date of Decision: April 29, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman