PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2005-D18

PROVIDER -
Liberty Village
Muncie, Indiana

Provider No.: 15-5400

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal

DATE OF HEARING -
May 17, 2004

Cost Reporting Period Ended -
December 31, 1995

CASE NO.: 98-2318

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to the National Premier Financial Services, Inc., and NPF VI, Inc., Costs/Program Fees was proper.

2. Whether the Intermediary's failure to allow $18,215 of related party depreciation was proper.

3. Whether the Intermediary's adjustments to decrease total respiratory therapy hours worked, unduplicated days, the cost of respiratory therapy services from outside suppliers, and $5,661 of related respiratory therapy expense was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement that is due to 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. See, 42 U.S.C. §1395(h), 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 (FI) 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Liberty Village (Provider) is a 64-bed skilled nursing facility located in Muncie, Indiana. On its cost report for fiscal year ended 12/31/95, the Provider claimed reimbursement for cost and program fees under an agreement that it had with National Premier Financial Services, Inc. and NPF VI, Inc. The Provider also claimed reimbursement for rental expenses on a facility secured from a related party and for respiratory services that were secured from outside sources. AdminaStar Federal (Intermediary) examined the cost report and disallowed substantial portions of the amounts claimed for all three areas. The specific history for each is as follows:

Issue 1: National Premier Financial Services, Inc., and NPF VI, Inc., Costs/Program Fees

During the fiscal year under review, the Provider was owned by Pilgrim Manor, Inc. Pilgrim Manor entered into an agreement with NPF VI and with National Premier Financial Services under which Pilgrim Manor agreed to sell its receivables. The agreement identified NPF VI as the "Purchaser" and National Premier Financial Services as the "Servicer". Under the agreement, the purchaser and the servicer appointed the Provider to act as the "subservicer." As the subservicer, the Provider conducted the servicing, administration and collection of the purchased receivables. The Provider established two separate lock box accounts. The first of these was called the Medicare Lockbox Account and was established in the Provider's name. Medicare/Medicaid & CHAMPUS payors were instructed to make payments to this account, and all collections related to those activities were deposited to the account as well. Payments to the Medicare Lockbox were swept on a daily basis by a trustee appointed by the purchaser to a trust account established/controlled by the purchaser. The second lockbox account was established in the servicer's name and was titled the Commercial Lockbox Account. All eligible payors, other than Medicare/Medicaid & CHAMPUS, were instructed to make their payments to this account. For the period ended 12/31/95, the Provider claimed $43,318 for program costs and fees related to the agreement. The Intermediary considered the agreement a sale of the Provider's receivables and the costs incurred by the Provider to effect collections of those receivables to be unrelated to patient care. The impact of the Intermediary's adjustment was a $6,500 reduction in Medicare reimbursement.

Issue 2: Related Party Depreciation

The Provider claimed rental expenses on its cost report for the facility that it rents from Liberty General Partnership. It is undisputed that the Provider and Liberty General Partnership are related parties and that the Provider's facility is rented from Liberty General. The Intermediary originally intended to adjust the rental expense to the ownership costs incurred by Liberty General Partnership as required by 42 CFR §413.17. That section generally limits ownership costs to the related party's interest and depreciation expenses. The Intermediary allowed the interest expense that it was able to identify from the Provider's records. However, the Provider failed to obtain from the related party the documentation needed to compute allowable depreciation expense for the building. Absent such support, the Intermediary disallowed the depreciation related to the building. The Medicare impact of the Intermediary's adjustment was a $950 reduction in Medicare reimbursement.

Issue 3: Outside Respiratory Therapy Services

The Provider purchased respiratory therapy services from outside suppliers during its operating year but offered no support from its records for the costs that it claimed. The Intermediary performed a detailed review and reconstruction of the services purchased. As a part of that reconstruction, the Intermediary accumulated therapy hours worked from the suppliers' time logs and invoices. The Intermediary also accumulated the expenses incurred by the Provider for the purchased services from the suppliers' invoices. Based on its review, the Intermediary adjusted the hours and expenses to the amounts evidenced by the suppliers' logs and invoices. The impact of the Intermediary's adjustment was a $9,600 reduction in Medicare reimbursement.

PARTIES CONTENTIONS:

Issue 1: National Premier Financial Services, Inc., and NPF VI, Inc., Costs/Program Fees

The Provider contends that the agreement reached with National Premier and NPF VI was not a sale but, rather, an attempt to finance current receivables. The agreement brought the collection expertise of National Premier and NPF to the Provider's operation and allowed the Provider to reduce its personnel costs by eliminating the need for a collection clerk. The Provider contends that the agreement was necessary to meet the needs of the Provider's residents.

The Intermediary contends that the agreement executed by the parties qualifies as a sale of assets and a legal transfer of the Provider's ownership in those assets under Generally Accepted Accounting Principles set forth in Financial Accounting Standards Bulletin 77. The Intermediary argues that collection of receivables that no longer belong to a provider is not an activity that is related to patient care and is not an allowable cost under 42 C.F.R. §413.9.

Issue 2: Related Party Depreciation

The Provider contends that related party depreciation is an allowable cost under the Medicare program. The Provider argues that it supplied a summary schedule to the Intermediary that fully supported its depreciation claim and, accordingly, the costs claimed should be allowed.

The Intermediary contends that the Provider was only able to support the interest expense incurred by Liberty General Partnership for the facility. The Provider failed to provide the related party's depreciation schedule that was requested by the Intermediary to support the depreciation expense related to the building. The Intermediary further argues that 42 C.F.R. §413.20 requires providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Absent supporting documentation, the Intermediary cannot allow the amounts claimed for depreciation.

Issue 3: Respiratory Therapy Services

The Provider contends that respiratory therapy expense is an allowable cost under the Medicare program. The respiratory therapy expense on the trial balance appears reasonable based upon a cost to charge analysis. The unduplicated days and hours of service are supported by a summary work paper prepared by the Provider that agrees with the cost report as filed.

The Intermediary contends that 42 C.F.R. §413.20 requires that claims for reimbursement must be supported by auditable financial/statistical data. The Intermediary developed its adjustments based upon the only verifiable source data available in the Provider's records. Absent verifiable documentation that supports the Provider's claimed hours and costs, the Intermediary considers its numbers the most reliable estimate for reimbursement purposes.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence presented at the hearing, finds and concludes the following:

Issue 1: National Premier Financial Services, Inc., and NPF VI, Inc., Costs/Program Fees

The central issue surrounding the program fees is the nature of the agreement between the Provider and NPF VI/National Premier Financial Services. While the Provider asserts that the agreement is a financing agreement, the Intermediary argues that the agreement is an actual sale of the receivables. The Board's review of the agreement indicated that the Provider agreed to "sell, transfer, assign, set over and convey to the Purchaser, without recourse, all right, title and interest in and to the purchased receivables."[1] The language of the agreement clearly indicates that both parties intended that the transfer be a sale of the receivables. Further, the Provider relinquished control over the receivables under the agreement and never controlled any of the funds that were collected. Although the Medicare account was nominally the Provider's, it was subject to the order and control of the Purchaser's trustee. The commercial account existed in the name of the servicer and was always beyond the Provider's control. Given the language of the agreement and its actual operating circumstances, the Board finds that the agreement was a sale of the receivables. The Board further finds that the collection of receivables that no longer belong to a provider is not an activity related to patient care and, therefore, is not an allowable cost under 42 C.F.R.§413.9. The Board concludes that the Intermediary properly adjusted the Provider's collection costs.

Issue 2: Related Party Depreciation

The dispute over rental expenses centers on the adequacy of the documentation offered in support of the amounts claimed. The controlling regulations for related party rentals appear at 42 C.F.R. §413.20, which requires that providers submit cost data that is adequate to support their claims and at 42 C.F.R. §413.17, which limits rental expenses from a related party to the costs of the related party's ownership (interest and depreciation).

In this case, the Provider contended that it had supplied documentation that supported its related party depreciation claim. However, the Board's examination indicated that the Provider's support consisted of a depreciation schedule that was developed for tax purposes. The schedule was not representative of the depreciation of the facility and made any association between the schedule and the costs claimed impossible. The Board considers the information offered by the Provider inadequate to support a claim for related party depreciation. Absent any additional information from the Provider, the Board must conclude that the Intermediary properly disallowed the depreciation.

[1] Sale and Subservicing Agreement, Article II, page 12.

Issue 3: Respiratory Therapy Services

The dispute over respiratory therapy service costs also centers on the adequacy of the documentation offered in support of the amounts claimed. The Provider prepared a summary work paper that it claims supports its unduplicated days and hours of service and agrees with the trial balance and the cost report as filed. However, both the work paper and the trial balance are unsupported by source documentation. The Board finds that, absent source documentation from which the summary was created, the information offered by the Provider is inadequate to support its claim for respiratory therapy costs. The Board concludes that the Intermediary properly adjusted the Provider's claim for respiratory therapy costs.

DECISION AND ORDER:

Issue 1: Owners Compensation

The Intermediary's adjustment is affirmed.

Issue 2: Related Party Depreciation

The Intermediary's adjustment is affirmed.

Issue 3: Respiratory Services

The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: January 6, 2005

Suzanne Cochran, Esquire
Chairperson