PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D5

PROVIDER -Confident Home Health Care
Dallas, Texas

Provider No. 45-7789

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Iowa

DATE OF HEARING-
August 9, 1996

Cost Reporting Period Ended -
July 31, 1994

CASE NO. 96-2054

INDEX

ISSUE:

Was the Intermediary's adjustment shifting nursing and home health aide costs to a private duty nursing cost center proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Confident Home Health Care ("Provider") is a Medicare certified home health agency located in Dallas, Texas. During the desk review of the Provider's July 31, 1994 cost report, Blue Cross and Blue Shield of Iowa ("Intermediary") determined that the Provider was providing private duty nursing and home health aide care. To bring the Provider's costs into compliance with appropriate regulations and instructions, the Intermediary reclassified a portion of skilled nursing and contracted home health aide costs into a nonreimbursable cost center. The adjustment resulted in a decrease in the Provider's Medicare reimbursable costs. The Provider appealed the adjustment to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C. F. R. §§ 405.1835-.1841. The amount of Medicare reimbursement in dispute is approximately $60,000.[1] The Provider is represented by John W. Jansak of Harriman, Jansak, Levy, & Wylie. The Intermediary is represented by Bernard Talbert, Esquire, Blue Cross and Blue Shield Association.

Facts:

During the fiscal year under appeal, the Provider provided both skilled and non-skilled services to a non-Medicare patient[2] on 271 days.[3] A licensed practical nurse visited the patient 5 days a week for 8 or 9 hours a day and devoted the time to providing skilled nursing and home health aide services. The patient's family provided care at all other times. The Provider's visits to Ms. X were recorded as Medicare equivalent skilled nursing visits on the cost report and then recorded as non-Medicare costs for purposes of cost apportionment.

Prior to becoming a patient of the Provider, Ms. X received her daily services from a private duty nursing company owned by the Provider owner's husband. A decision was made that it was not profitable to operate a separate private pay agency; Ms. X was subsequently

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1 Provider Position Paper at 2 and Intermediary Position Paper at 4.

2 Since the appeal centers on the Provider's visits to one particular non-Medicare patient, the patient will be referred to as "Ms. X" throughout this decision. Several years earlier, Ms. X was the victim of a surgical anesthesia accident. She was in a vegetative state with no hope of improvement and needed full time attention. See Tr. at 34.

3 Tr. at 29.

transferred from the husband's business to the Provider.[4] The nurse who worked for the husband's company became a Provider employee and continued to provide nursing services to Ms. X.[5]

The main area of disagreement between the parties is the level of skilled care[6] provided to Ms. X and whether the care would qualify as Medicare equivalent skilled nursing visits. The Provider contends that Ms. X received approximately 32 hours of skilled care and approximately 10 hours of non-skilled home health aide type care per week.[7] The Provider counted this as five skilled nursing visits on the cost report. The Intermediary, through its medical review staff, determined skilled nursing care was only provided to Ms. X for 2 hours per day or 10 hours a week, with 18.75 hours of non-skilled care per week.[8] Although the Intermediary agreed that some skilled care was provided, the length of the care was neither definite nor predictable. Thus, the services rendered to Ms. X were not comparable to skilled nursing visits delivered to other Provider patients.

The Provider included the costs of Ms. X's care in the skilled nursing cost center on the Medicare cost report. Each daily encounter in Ms. X's home was counted as a visit by the Provider. The Intermediary concluded that all services furnished to Ms. X were private duty nursing services and were reclassified to a non-reimbursable cost center. The visits for Ms. X were also removed by the Intermediary from the total skilled nursing visit count on the cost report. Since a non-reimbursable cost center was established, administrative & general costs were allocated to the cost center. The adjustment related to Ms. X was calculated by the Intermediary as follows:

Nursing hours for Ms. X	2,166
Nursing salary/hour	$ 17
Nursing salary for Ms. X	$36,822
Benefits (% of salaries)	6,172
Total salary & benefits	$42,994

Intermediary Position Paper at 5.

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4 See Tr. at 38-39.

5 See Tr. at 55-56.

6 The reference to skilled care is in the context of what Medicare would cover as a home health skilled nursing benefit for a Medicare beneficiary.

7 Tr. at 71.

8 Intermediary Exhibit 8, Pg. 2.

Following is a comparison of skilled nursing visit statistics before and after the adjustment for Ms. X:

	Total Skilled Nursing Visits	Medicare Skilled Nursing Visits Medicare Visits	Percentage of
As Filed	4,720	4,336	91.8%
As Audited	4,449	4,336	97.5%

Intermediary Post Hearing Brief at 4.

The Provider's charge for a Medicare skilled nursing visit was $110. A rate of $33 per hour ($264 or $297 per day based on an 8 or 9 hour day, respectively) was the charge negotiated with the private insurance company for providing services to Ms. X.

In addition to the salary and benefit adjustment of $42,994 for Ms. X, the Intermediary also reclassified $17,914 in home health aide salaries to the same non-reimbursable cost center as the nursing salaries were reclassified. According to the Intermediary, these costs are related to contracted home health aides who provided private duty services to patients other than Ms. X.[9] The Intermediary's witness indicated the adjustment was made for aides providing 24 hour shifts for which they were paid $120 per shift.[10] There was no cross examination by the Provider on the aide adjustment; however, it did mention during opening statements at the hearing (Tr. at 7) and again in the Post Hearing Brief (Post Hearing Brief at 1) that it was not in agreement with the Intermediary's adjustment since home health aide services are covered by the Medicare program.

PROVIDER'S CONTENTIONS:

The Provider contends that services furnished to Ms. X were Medicare equivalent services whether or not they were skilled or home health aide services. Therefore, the Provider maintains that the salary costs for services rendered to Ms. X should be included in the skilled nursing cost center on the cost report and the visits to Ms. X should be included in the total visit count on the cost report. The Provider maintains that each day a combination of these services was furnished to Ms. X constitutes one visit. The Provider bases its contention of 42 C.F.R. § 409.43(b)(4) which states that:

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9 Intermediary Position Paper at 5.

10 Tr. at 120.

> (4) if a nurse furnishes several services during a visit (for example, skilled nursing care and home health aide services), that constitutes only one visit. (emphasis added).

Id.

The Provider asserts that since the Intermediary agrees that Medicare equivalent skilled services were furnished to Ms. X each day,[11] a visit should be counted as provided under 42 C.F.R.
§ 409.43.

The Provider's witness testified that based on her review of the nursing notes, Ms. X was receiving both Medicare equivalent skilled nursing and home health aide services each day. When the nurse was not administering skilled care, the nurse offered home health aide type of care. According to the Provider's witness, home health aide or non-skilled services related to the Medicare definition are personal care, hands-on care such as bathing, hygiene, feedings, as well as assistance with transfer and ambulation. They are all Medicare covered services.[12] The witness testified that each hour's activity indicated on the nursing note represented skilled or non-skilled (but Medicare equivalent) home health aide service.[13]

The Provider disputes the Intermediary's contention that the treatment of Ms. X is private duty nursing. The Provider points out that the Intermediary's own medical reviewer (Intermediary Exhibit 8) found that Ms. X received a minimum hands-on nursing care of 10 hours and a minimum hands-on home personal care (or home health aide services) of 18.75 hours, for a total of 28.75 hours per week of Medicare equivalent care, thus contradicting the Intermediary's contention that Ms. X's care is private duty.[14]

The Provider also rejects the Intermediary's argument that since the care provided to Ms. X was not intermittent (i.e. did not have a definite or predictable end), it is not a Medicare equivalent covered service. The Provider, in fact agrees with the Intermediary that the care was not intermittent, but, asserts the care was "part-time" and is therefore allowable under Home Health Agency Manual ("HIM-11") § 206.7(A).[15]

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[11] Tr. at 162-163.

[12] Tr. at 66.

[13] Tr. at 84, Provider Exhibits 8 and 9, Provide r Post Hearing Brief at 4.

[14] Provider's Post Hearing Brief at 9.

[15] Id.

The Provider notes that Medicare rules allow coverage of 35 hours of part-time service a week. HIM-11 § 206.7 The Provider contends that based on its witnesses' analyses of Ms. X's nursing notes, it was clear that Ms. X received at least 35 hours of Medicare equivalent part-time skilled and home health aide services per week.[16] The Provider also points out that HIM-11 § 206.7C[17] describes a case where a person received chronic care 24 hours a day. Of this care, 35 hours per week were allowable by Medicare for an indefinite period.

In conclusion, the Provider maintains that since the Intermediary agreed that skilled services were furnished each day, a visit should be counted under 42 C.F.R. § 409.43. The Provider asserts that since they were Medicare equivalent services, there should have been no adjustment to a non-reimbursable cost center. The Provider contends that whether it was 2 hours or 6 hours of skilled nursing care rendered throughout the day, it was still a visit.[18]

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the audit adjustments which reclassified skilled nursing and home health aide costs to a non-reimbursable cost center were made in accordance with the provisions of Medicare regulations 42 C.F.R. § 413.53-Determination of Costs of Services to Beneficiaries, Provider Reimbursement Manual ("HCFA Pub. 15-1"), § 2104.2-Private Duty Personnel and HIM § 206.7(B).[19]

The Intermediary points out that according to HCFA Pub. 15-1 § 2104.2: "The costs of private-duty nurses and other private-duty attendants are not included in allowable costs. Services of private nurses and attendants are specifically excluded from coverage by law." Id.

Based on the Intermediary's review of the Plan of Treatment (Exhibit I-2) and the nurses notes (Exhibit I-3) for Ms. X, it determined that the visits should be classified as private duty for the following reasons:

1. The level of care given to Ms. X is a different level of care than skilled intermittent care. The majority of services provided in the 8 hour shift did not require the services of a skilled nurse.

2. The visits are significantly longer in duration than an actual skilled nursing visit. Excluding the visits to Ms. X, the skilled visits to the Provider's other patients

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16 Id, See also Provider Post Hearing Brief, Exhibit A, Exhibit C, pg 2..

17 Id.

18 Tr. at 184.

19 Intermediary Position Paper at 6.

averaged 2.71 hours.[20] There is a significant difference between a normal skilled visit and the 8 hour visits to Ms. X.

3. A different charge structure is being used for Ms. X's visits. At $33 per hour, these visits are being billed quite differently than the Provider's skilled nursing visits, which are billed at $110 per visit. As there is a different charge for Ms. X, this further suggests there is a different level of care being provided.

4. The Provider claims that full time care (i.e. 8 hour shifts) could possibly be allowed if it was for a "temporary, but not indefinite period of time." Since care was provided to Ms. X beyond this fiscal year, the patient does not conform to this definition.

Intermediary Position Paper at 6-7.

The Intermediary points out that skilled intermittent care is defined by HHA § 206.7(B). "Intermittent" means:

> "Up to and including full-time (i.e. 8 hours per day) skilled nursing and home health aide services combined which are provided and needed 7 days per week for temporary, but not indefinite, periods of time up to 21 days with allowances for extensions in exceptional circumstances where the need for care in excess of 21 days is finite and predictable"

HIM-11 § 206.7 (B)

The Intermediary contends that services have been provided to Ms. X for more than just the year under appeal, 1994.[21] Therefore, it supports the fact that the level of service is other than skilled intermittent care, as the length of care is neither definite or predictable as required by the above definition.

The Intermediary acknowledges that some of the services provided to Ms. X required skilled nursing care and that daily contact of 8 or 9 hour duration might be acceptable for a limited period of time.[22] Here, however, the patient had a permanent need for 8 hours of daily coverage for 5 days a week. The fact that other patients received an average of 66 visits per year and Ms. X received 271 supports the Intermediary's position that her care was

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20 Id.

21 Intermediary Position Paper at 7, Tr. at 38.

22 Intermediary Position Paper at 7, Intermediary Post Hearing Brief at 7.

fundamentally different.[23] Therefore, Ms. X's level of care does not meet the definition of intermittent care and consequently is not considered skilled care. The Intermediary contends that an 8 hour visit is far above the average.

In addition, the Intermediary points out that if the Provider is charging the patient $33 an hour, over an 8 hour visit, the level of care must be different than that given in a Medicare covered skilled nursing visit which generates a charge of $110.[24] Therefore, if the level of care is different, it should not be included in the skilled nursing cost center as required by 42 C.F.R. § 413.53. Also, the Intermediary points out that the Provider's CPA firm originally categorized the revenue from Ms. X's care as private duty nursing. See Intermediary Exhibit I-1.

The Intermediary also notes the discovery at the hearing that a nursing service operated by the Provider's husband was the prior care giver for Ms. X. The Intermediary contends the shift of her care to the Provider was an economic decision, not a medical one. The reassignment from a private duty company to the Provider strongly supports the Intermediary's classification of Ms. X's care as non-allowable private duty nursing care.[25]

The Intermediary rejects the Provider's argument that if Ms. X received some skilled care, the visit and costs should be lumped in with skilled nursing services. The Intermediary contends the difference between Ms. X's services and the other skilled nursing patients is extreme. The daily time required and the need based upon Ms. X's condition is permanent. The Intermediary believes the charge discrepancy is the best evidence of the Provider's own view that Ms. X's services are not comparable to other services reported as skilled nursing care on the cost report.

In conclusion, the Intermediary believes that private duty nursing is the most accurate description for what the Provider furnished to Ms. X. The Intermediary contends the nature of the services did not change just because the care was transferred from a private duty nursing service to the Provider. The Intermediary asserts it was an ownership family based economic decision; it did not redefine the services.[26]

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23 Intermediary Post Hearing Brief at 5, 7.

24 Intermediary Position Paper at 7.

25 Intermediary Post Hearing Brief at 8.

26 Intermediary Post Hearing Brief at 9.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 409.43	-	Home Health Service Visit
§ 413.53	-	Determination of Costs of Services to Beneficiaries

2. Program Instructions-Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1):

§ 2104.2	-	Private-Duty Personnel

3. Program Instructions-Home Health Agency Manual, (HIM-11):

§ 206.7	-	Part-time or Intermittent Home Home Health Aide and Skilled Nursing Services

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing briefs, finds and concludes as follows:

Evidence in the record shows that some Medicare equivalent skilled nursing services were administered by the Provider to Ms. X. The record also shows that some Medicare equivalent home health aide services were administered by the Provider to Ms. X. The Board recognizes that Medicare pays for both skilled nursing and home health aide services. The Board places great weight on both the Provider's and Intermediary's witnesses' medical review of the services rendered to Ms. X. Therefore, the Board concludes that at least 10 hours of skilled nursing care and 18.75 hours of home health aide services were rendered each week by the Provider in Ms. X's home.[27]

The Board sees no reason why a non-Medicare skilled nursing visit for Ms. X cannot be included in total skilled nursing visits by the Provider on its Medicare cost report. The Board bases this conclusion on 42 C.F.R. § 409.43(b)(4) which states: "[i]f a nurse furnishes several services during a visit (for example, skilled nursing care and home health aide services), that constitutes only one visit." Id. In addition, HIM-11, § 218.1, defines a visit as, ". . . a personal contact in the place of residence of a patient made for the purpose of providing a

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[27] See Intermediary Exhibit I-8, Pg. 2.

covered service by a health care worker on the staff of the home health agency . . ." Id. Thus, the Board finds and concludes that a visit was in fact rendered to Ms. X on each daily encounter by the Provider's nurse in Ms. X's residence.

The Board finds nothing in evidence which defines "private duty nursing". Accordingly, the Board rejects the Intermediary's contentions that all of Ms. X's services should be reclassified to private duty nursing. One of the Intermediary contentions for reclassifying Ms. X's care as private duty is, "[t]he level of care given is a different level of skilled intermittent care. The majority of services provided during the 8 hour shift did not require the services of a skilled nurse. . ."[28] The Board disagrees with the Intermediary's conclusion that because Ms. X received a different level of care than intermittent skilled care, then the care should all be classified as private duty nursing. As noted above, the Board places great weight on the medical analysis of Ms. X's condition done by both the Intermediary and the Provider. In fact, Intermediary Exhibit I-8 notes that at least 10 hours of skilled nursing care and 18.75 hours of home health aide services were rendered in a 40 hour week. Based on this analysis, the Board concludes that 72 percent (10 hours skilled care plus 18.75 home health aide care divided by 40 hour week) of the nursing salaries and benefits for services provided to Ms. X should be classified as Medicare equivalent services and consequently should be included with other Medicare equivalent salaries and benefits on the Medicare cost report. The Board also concludes that the remainder of the weekly salaries and benefits for Ms. X's services (11.25 hours or 28 percent) should be classified as non-Medicare equivalent services and should be moved to the non-reimbursable cost center on the cost report entitled "Private Duty Nursing".

The Board also disagrees with the Intermediary's contention that because, "[t]he visits [to Ms. X] are significantly longer in duration than an actual skilled nursing visit,"[29] Ms. X's services should be considered private duty nursing. The Board notes that neither the regulations nor the Provider Reimbursement Manual link hours and visits.

The Board also disagrees with the Intermediary that the charge structure[30] is indicative of the level of care given to Ms. X.[31] The Board finds the charge for Ms. X's services appears reasonable when considering the number of skilled nursing and home health hours actually rendered in a day to Ms. X. In fact, when analyzed and broken down, the charges for Ms. X are not significantly different from the Provider's regular charges.

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28 Intermediary Position Paper at 6.

29 Id.

30 The Provider charges approximately $233 a visit (8 hrs. x $33) for Ms. X. The Provider charges $110 for a skilled nursing visit to other patients.

31 Intermediary Position Paper at 6.

The Board rejects with the Intermediary's contention that, because the care given to Ms. X was not intermittent care (i.e. temporary and for a definite period of time), the services would not be covered as Medicare equivalent and should therefore be classified as private duty nursing. According to HIM-11 § 206.7, Medicare covers either part-time or intermittent home health aide and skilled nursing services (emphasis added). The Board agrees with the Intermediary that services provided to Ms. X are not intermittent, however, it finds that the services meet the definition of part-time and are therefore considered Medicare equivalent services.

In conclusion, the Board finds that the Provider did in fact provide Medicare equivalent services to Ms. X, a non-Medicare patient. Therefore, the Board concludes that the Provider's method of counting visits for services to Ms. X was correct. Ms. X's visits (271)[32] should be included in the total skilled nursing visit count on the Provider's Medicare cost report. Accordingly, the total skilled nursing visit count would remain as submitted, 4720.[33]
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The Board also concludes that 72 percent of the skilled nursing salaries and benefits (72% of $42, 994) should be included with other skilled nursing salaries on the Provider's cost report. The remaining 28% should be reclassified to private duty nursing on the cost report. In addition, the amount of square footage assigned to private duty nursing by the Intermediary should be adjusted accordingly.

Regarding the Intermediary's $17,914 adjustment for contracted home health aides, the Board, having found no evidence or testimony in the record of the Provider's rationale for disputing this adjustment, concludes it was proper.

DECISION AND ORDER:

The Intermediary's adjustment reclassifying skilled nursing salaries and benefits to the private duty nursing cost center is modified as discussed above. The Intermediary's adjustment reclassifying contracted home health aide costs to private duty nursing is affirmed.

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[32] Tr. at 28, 129.

[33] Intermediary Exhibit I-6, pg. 2.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman