PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D46

PROVIDER -
Universal Rehabilitation Services, Inc.
Horsham, Pennsylvania

Provider No. 39-6563

vs.

INTERMEDIARY -
Independence Blue Cross

DATE OF HEARING-
April 10, 1996

Cost Reporting Period Ended -
September 30, 1989

CASE NO. 92-1582

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ISSUE:

Was the Intermediary's adjustment to the Provider's reasonable costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Universal Rehabilitation Services, Inc. ("Provider"), is a rehabilitation agency located in Horsham, Pennsylvania, and is an outpatient provider of physical therapy ("PT"), occupational therapy ("OT") and speech language pathology ("ST") services. The Provider furnishes services exclusively to geriatric patients residing in nursing facilities. The Provider's Medicare utilization rate for the period in dispute was approximately ninety-nine percent (99%).[1] The Provider's fiscal intermediary for the period in dispute was Independence Blue Cross ("Intermediary"). For the fiscal period in dispute, the Intermediary conducted an audit of the Provider's cost report, and issued a Notice of Program Reimbursement ("NPR") dated September 30, 1991.[2] The Provider appealed several adjustments made on that NPR and subsequently received a revised NPR dated June 15, 1992, containing an adjustment to "reasonable costs" in the amount of $897,291.[3] These facts are not in dispute.

Between the date of the original NPR and the revised NPR, the Intermediary testified that it became aware of an ongoing Office of Inspector General ("OIG") investigation of the Provider and several of its principals.[4] The Intermediary referred the matter to the OIG for investigation. The investigation resulted in a grand jury indictment charging the Provider and several of its principals with twenty-one (21) counts of filing false Medicare claims and seventeen (17) counts of mail fraud. Following a lengthy trial, the Provider and its principals were acquitted on all counts of filing false Medicare claims, and all but one count of mail fraud.[5] The Judge in this case has taken under advisement whether to overturn the conviction on this count based on the fact that there has been no underlying fraud established.[6]

At the Provider Reimbursement Review Board ("Board") hearing, the Provider's counsel questioned the Intermediary's witness regarding the relationship between the OIG

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1 Provider Position Paper at 2.

2 Id. at 1.

3 Provider Exhibit P-3.

4 Transcript (hereinafter "Tr") at 230-231.

5 Provider Post Hearing Brief at 2.

6 Id.

investigation and the reasonable cost adjustment.[7] The Intermediary's witness testified that, as a direct result of the fraud investigation, it undertook to re-examine the Provider's costs in spite of the fact that the Provider had been audited and adjustments had been made to specific components of cost.[8] As part of its own investigation and further examination of the Provider's costs precipitated by the fraud investigation, the Intermediary conducted a "survey" of other therapy providers that it believed to be comparable to the Provider.[9] The Intermediary conducted the survey using outpatient therapy providers located in Pennsylvania for which settled cost reports existed as of September 30, 1989.[10]

The survey arrayed information obtained from the cost reports of twenty-one (21) outpatient therapy providers.[11] The Intermediary calculated a Medicare cost per visit for each provider in the survey, by dividing its total Medicare costs by the number of Medicare visits. The Intermediary then calculated an average Medicare cost per visit for all of the providers in the survey, and applied a standard deviation to arrive at a reasonable cost per visit of $95.75. Comparing that figure to the Provider's average cost per visit of $160.51, the Intermediary concluded that the Provider's average Medicare cost per visit was "substantially out-of-line" with the costs of "comparable" providers. Accordingly, the Intermediary reopened the Provider's cost report to make a "reasonable cost" adjustment to the Provider's total cost per visit.[12]

The Provider timely appealed the adjustment to reasonable costs to the Board and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in controversy is approximately $897,000.[13] The Provider was represented by E. Michael Flanagan, of Gardner, Carton & Douglas. The Intermediary's representative was Michael F. Berkey, CPA, of the Blue Cross and Blue Shield Association.

PROCEDURAL MATTERS- MOTION TO DISMISS

On August 19, 1996, the Intermediary filed a motion to dismiss the instant case because the Provider did not move to add this case to other Provider appeals pending before the Board.

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7 Tr. at 230-235.

8 Tr at 233, 235.

9 Tr at 230.

10 Tr. at 178.

11 Tr. at 217-218. See also, Provider Exhibit P-4.

12 Provider Post Hearing Brief at 3.

13 Intermediary Position Paper at 3, Provider Position Paper at 16.

The Intermediary points out that on June 25, 1996 it learned that the same survey used by the Intermediary in the present case was used by another intermediary to make similar adjustments to a New Jersey provider related to the Provider in the present case. The New Jersey provider filed appeals with the Board for three different fiscal years.[14] The Intermediary points out that all three appeals were filed prior to the present case going to hearing. The Intermediary also notes that the New Jersey appeals were filed as single appeals, after the Provider in the present case filed its appeal and before the hearing.

The Intermediary contends that since all four cases involve related parties and a common issue, they should have been pursued as a group. See 42 C.F.R. § 405.1837(b) The Intermediary contends that when the New Jersey appeals were submitted, there was no move on the Provider's part to bring the issue as a group. Accordingly, since the appeals were not merged as a group, the Intermediary contends that all four appeals should be dismissed.

The Provider contends the issues are not identical in the present case and the New Jersey cases. The Provider explains that its argument in the present case is that the survey used by the Intermediary is flawed since it did not use comparable providers. The Provider acknowledges that the same survey was used for the adjustment in the New Jersey appeals, however its argument in the New Jersey appeals was that the survey was not analyzed for comparability to New Jersey providers. The Provider also points out that the present appeal is for a fiscal year 2 years prior to the New Jersey appeal.

The Provider contends that both intermediaries were aware that the adjustments were being vigorously contested. The Provider further contends that the Intermediary should have raised the jurisdictional issue at the time the issues were filed. Therefore, the Provider maintains that the Intermediary's claim for lack of jurisdiction strains credulity.

SUBSTANTIVE ARGUMENT

PROVIDER'S CONTENTIONS:

The Provider maintains that a past criminal investigation is irrelevant to the case at hand. The Provider asserts the sole relevant issue to be determined by the Board is whether the Intermediary's adjustment to the Provider's reasonable costs was proper. The Provider maintains that the Intermediary has failed to meet its burden of proving that the Provider's costs are substantially out-of-line and, therefore, unreasonable. Absent such proof, the Provider contends its costs are allowable in their entirety regardless of how widely they may vary from the costs of other providers. The Provider contends the survey upon which the Intermediary's reasonable cost adjustment is based is invalid because it is flawed on its face, in that it fails to identify and compare "comparable" providers as required by Medicare law, regulation and program instructions. Moreover, the survey has been applied inappropriately

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[14] Intermediary Motion to dismiss at 1.

as a cost limit, in a manner that exceeds the authority of the Intermediary. Accordingly, the Provider believes the survey should be invalidated and its costs should be allowed as reasonable. In support of its position, the Provider asserts that:

1. The criminal investigation is irrelevant to this case.
2. The reasonable cost adjustment is improper because it is based on a flawed survey.
3. The Intermediary's survey was improperly applied to total costs.

Following are the Provider's arguments to support each of the above assertions.

1. *The criminal investigation is irrelevant to this case.*

The Provider contends the criminal allegations are not applicable to its cost report. The Provider points out that the false claims allegations made by the OIG and heard at the trial were that the Provider and its employees altered, forged or destroyed speech therapy documentation in an effort to be reimbursed by Medicare for speech therapy services.[15] The Provider explains that these allegations were based on clinical documentation submitted in support of individual claims for reimbursement and, as such, are unrelated to the costs claimed on the Provider's cost report. The Provider contends that a false claim, even if proven, would have had no impact on its costs as reported on its cost report.[16] In addition, the Provider contends that a false claim, if proven, would not necessarily be an indication that its costs were "substantially out-of-line" with the costs of other providers. Also, the Provider points out that the Intermediary's witness testified to the fact that a finding of fraud would not necessarily affect a provider's costs to the extent they would be substantially out-of-line.[17]

The Intermediary points out that the criminal investigation mentioned above has been adjudicated and the Provider and its principals acquitted on all counts of filing false Medicare claims and all but one count of mail fraud. The trial judge has received the parties' Motion for Judgment of Acquittal, filed pursuant to Rule 29 of the Federal Rules of Criminal Procedure, and has taken under advisement whether to overturn the one outstanding mail fraud conviction based on the absence of a conviction for an underlying fraud.[18] The Provider, therefore, maintains that any references to the OIG investigation is irrelevant to this appeal and should be disregarded, except insofar as the acquittal on all Medicare counts is concerned.

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15 Provider Post Hearing Brief at 4.

16 Id. at 5.

17 Tr. at 234.

18 Provider's Post Hearing Brief at 5.

2. *The reasonable cost adjustment is improper because it is based on a flawed survey.* The Provider points out that in support of its adjustment, the Intermediary relied on a "survey" of outpatient therapy providers to determine that its costs were substantially out-of-line with costs of "comparable" providers.[19] The Intermediary produced an expert witness to provide testimony concerning the validity of the survey and statistical methods employed.[20] The Provider maintains that the testimony adduced from both the Intermediary's expert on cross examination as well as the Provider's expert demonstrates that the Intermediary did not make any attempt to evaluate the comparability of providers in the survey.

The Provider contends that the Intermediary has the burden of proving that its costs are substantially out-of-line, and that the Intermediary has failed to meet that burden with its survey. The Provider points out that the Intermediary's own witness testified that it is the Intermediary's burden to have produced a survey to be able to make a substantially out-of-line determination and to ensure that the survey is correct.[21] He further testified that, when an intermediary becomes involved in determining whether a provider's costs are substantially out-of-line, it is the intermediary's burden to demonstrate that the provider's costs are substantially out-of-line.[22]

As noted in the Board's opinion in Girling and Associates Home Health Services, Inc. v. Mutual of Omaha:[23]

> [I]t is only fair that the burden of proof in the "substantially out-of-line" test be on the Intermediary. This conclusion is supported not only by the previously cited Board Decision but also by the language of 42 C.F.R. § *405.451 (recodified at* 413.9) itself... [S]ince the Intermediary is the one who has determined that the Provider's costs are allegedly substantially out-of-line, the Intermediary must bear the burden of producing evidence to that effect. If that burden is not met, it must be presumed that the provider's costs under review are reasonable.

Id.

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19 Intermediary Exhibit I-24.

20 Tr. at 171.

21 Tr. at 206-207.

22 Tr. at 229.

23 Girling and Associates Home Health Services, Inc. v. Mutual of Omaha, PRRB Dec. No. 78-D73 (Oct. 31, 1978), Medicare & Medicaid Guide (CCH) ¶ 29,489 (Provider Exhibit P-28).

The Intermediary's witness read into the record the relevant portions of 42 C.F.R § 413.9(c)(2),[24] the regulation governing reasonable costs and the "substantially out-of-line" determinations.[25] The Provider points out that the regulation specifically provides that, in comparing a particular provider's costs to the costs of other providers, the other providers must be in the same area, and must be similar in size, scope of services, utilization, and other relevant factors. The Provider contends that none of these significant factors were taken into consideration by the Intermediary in conducting the survey.

The Provider contends that the providers in the survey are not comparable in type and that the Intermediary made no effort either to identify the different types of providers in the survey or account for the vast differences in costs and reimbursement methods for the various providers, as required by the regulation and program policy.[26] The Provider points out it is an outpatient provider of three different types of therapy services and furnishes services exclusively to geriatric patients in the nursing home setting.

The Intermediary's witness testified that it normally tries to include similar providers in its surveys and that the only criteria used here to determine similarity among the surveyed providers was that they all furnished outpatient therapy services and all had settled cost reports.[27]

The Provider points out that in Summit Nursing Home v. Prudential Insurance Company of America,[28] the Board reversed the Intermediary's reasonable cost adjustment of a portion of the physical therapy expense incurred by the provider. Although the intermediary surveyed thirteen other New Jersey providers, none of the providers surveyed employed physical therapists, whereas the provider whose costs were at issue did employ therapists. The intermediary's survey, like the survey at issue in this case, also failed to distinguish between actual treatments and modalities. The Board found that the survey was flawed because: (1) there was no definition of treatment in the studies; (2) there was no adjustment for the scope of services; and (3) the cost of providing physical therapy services through employees was

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24 Intermediary Exhibit I-12.

25 Tr. at 190.

26 Provider's Post Hearing Brief at 7-8.

27 Tr. at 197.

28 Summit Nursing Home v. Prudential Insurance Company of America, PRRB Dec. No. 88-D29 (Sept. 1, 1988), Medicare & Medicaid Guide (CCH) ¶ 37,408 (Provider Exhibit P-29).

not comparable to providing physical therapy services under contract. For those reasons the Board stated:

> [T]he Intermediary, having failed to develop an appropriate peer group, did not prove the provider was imprudent. Therefore, the provider's costs stand as claimed.

Summit, CCH ¶ 37,408.

The Provider maintains that critical factors were not taken into consideration in the development or application of the survey. Therefore, the notion that all providers in the survey are comparable within the meaning of the substantially out-of-line rules is not supportable.

The Provider contends the Intermediary has failed to identify providers in the survey that are similar in size, as measured by the number of visits reported, or to account for any differences in the number and mix of visits in each service category that affects costs. The Provider notes that the Intermediary's survey compared providers with reported Medicare visits of between 24 and 63,841.[29] The Intermediary settled the Provider's 1989 cost report with 13,822 Medicare visits.[30] To the extent that the size of a provider may be measured by the number of visits it performs, the Provider contends that it has not been compared to other providers that are similar in size, as required by the regulation and program instructions.

The Intermediary's witness testified that it did not make a decision about which size criteria to use in evaluating the providers in the survey because the Intermediary simply used all OPT providers.[31] The Provider believes the witness thus inferred that, where all providers are used, no size comparison is necessary.

The Provider also argues that the Intermediary has failed to investigate whether the providers in the survey bill for services in the same manner, and had failed to account for such differences in the survey. To the extent the various providers in the survey report visits in a different manner, the Provider contends the Intermediary performed no normalization of the visits to account for these differences.

The Provider notes that the definition of a visit is currently a matter of substantial controversy

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29 Intermediary Exhibit I-24.

30 Tr. at 106.

31 Tr. at 198.

in the rehabilitation industry.[32] The Provider contends the definition of a visit and how visits are reported is critical to any valid comparison of a provider's cost per visit. Notwithstanding the size of the providers used in the survey, the Provider contends the Intermediary's failure to ascertain whether the providers defined visits differently, and the absence of any attempt to account for such differences by itself makes the survey invalid.

The Provider contends that its scope of services is not comparable to the providers in the survey. The Provider contends the Intermediary's use of an average cost per visit for all three therapy services in its survey fails to account for the differences among the types of therapy services that can lead to variations in the cost per visit. The Provider testified that, assuming different therapy services have different corresponding costs, a provider furnishing a greater number of higher cost services would have a higher average cost per visit.[33] Thus, the Provider points out that a provider furnishing only one therapy service would not have an average cost per visit comparable to a provider furnishing all three therapies, particularly where the provider furnishing only one service furnishes the least expensive service. While the Provider's average cost per visit for all three therapies, as calculated by the Intermediary, was $160.51, the actual cost per visit for that period for each individual therapy service varied according to type of service. The Provider contends the survey failed to account for difference in the mix and volume of the therapy services among the various providers.[34]

The Provider points out that according to the Intermediary's testimony, the Intermediary failed to verify whether it was the only provider in the survey that furnished all three therapy services
in the years surveyed, or whether any of the other providers furnished all three therapies. The witness also testified that he did not know whether the other providers in the survey had the same mix of PT, OT and ST services as this Provider, however did acknowledge that furnishing all three therapies requires more management, increased quality assurance, and additional recruiting of personnel.[35]

The Provider maintains these factors would contribute directly to higher costs for an agency furnishing all three therapy services than an agency furnishing only one therapy. The Provider contends that because of the significant disparity in costs per visit among the three therapies, the survey should have taken into account the mix of services furnished by the providers in the survey. The Provider further contends that every attempt should have been made by the Intermediary to compare it to providers with a similar mix of services, or to

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32 Provider Post Hearing Brief at 9.

33 Tr. at 93-94.

34 Tr. at 207-209. See also, Provider’s Position Paper at 23-25.

35 Tr. at 204-207.

account for a different mix, such as by calculating a separate cost per visit for each of the three therapy services.

The Provider also believes the Intermediary's survey fails to consider the utilization patterns of the geriatric nursing home population, including higher patient acuity, that contribute to higher costs for providers serving that community. The Provider contends the survey does not compare it to other providers with similar patient demographics.

The Provider also contends the Intermediary's survey fails to compare the Provider to other providers in the same geographic area as required by the regulations and Intermediary Letter 78-16.[36] Based on information provided at the hearing, the Intermediary believes the allowable cost per visit should be increased to take into account the area wage differential for the geographical area where the provider is located.[37]

The Provider also contends that the Intermediary has failed in its survey to take into account "other relevant factors" in accordance with 42 C.F.R. § 413.9(c)(2), that relate to costs. The Provider discussed "downtime" for therapists, as well as salary equivalency guidelines for physical therapists.[38]

The Provider points out that the Intermediary's witness indicated that he believed the Medicare salary equivalency guidelines for physical therapy did not affect a rehabilitation agency's cost per visit.[39] The Provider maintains that the effect of the guidelines is to artificially depress the cost of PT services furnished under contract and thus, to further distort the differences in cost between providers of PT services only, and providers of other services, or providers using employees for PT. The Intermediary's witness acknowledged that the survey does not distinguish between those providers using employees and those using contractors, and does not consider this factor in assessing comparability.[40]

The Provider points to testimony where the Intermediary's witness indicated that the providers in the survey were comparable only in the sense that they all furnished some type of outpatient therapy services, and they all had been issued NPRs, i.e., their cost reports were

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36 Provider Exhibit P-22.

37 Intermediary Post Hearing Brief at 7.

38 Provider Post Hearing Brief at 16.

39 Tr. at 242-244.

40 Tr. at 244-245.

settled.[41] The Provider maintains that settlement of a cost report has nothing whatsoever to do with comparability of providers. The Provider asserts that the mere issuance of an NPR does not indicate anything substantive about a provider other than that it is a cost reimbursed provider. In addition, even if the issuance of an NPR were a valid basis for comparison among providers, the Intermediary here made no subsequent attempts to adjust the survey to include later settled cost reports, reopened cost reports, or appealed cost reports. The Provider maintains that these factors could influence the average cost per visit of the providers in the survey, particularly where providers with later settled cost reports have a higher cost per visit than the average already calculated. This should have been taken into account in applying the survey.

3. *The Intermediary's survey was improperly applied to total costs.*

The Provider explains that even if the Intermediary's survey had been constructed properly to compare truly comparable providers, it has been applied inappropriately to adjust the Provider's total costs.[42] The Provider asserts that this is contrary to Medicare program policy and case law interpretations that require surveys to be applied to components of cost. In applying the survey to total costs, the Provider believes the Intermediary essentially has created a cost limit beyond the scope of its authority.

The Provider points to Home Health Services of Metropolitan Washington D.C. v. Office of Direct Reimbursement,[43] ("Metropolitan") in which the HCFA Administrator upheld the Board's determination that the Intermediary's substantially out-of-line adjustment was improper. The intermediary contended that its imposition of a cost per visit cap on the provider was justified by its determination that the provider's costs were substantially out-of-line. The Administrator disagreed, however, stating that the proper use of the substantially out-of-line guidelines would serve as an indicator that a provider's costs might not meet the requirements for reasonableness in 42 C.F.R. § 405.451. (Recodified at 42 C.F.R. § 413.9) The Administrator added that "[s]uch an indication could lead to the valid further investigation of specifically what costs incurred by a provider are out-of-line, and why. Any application of guidelines or limits in this manner further requires the consideration of extenuating circumstances." Metropolitan, CCH ¶ 32,089.

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41 Tr. at 249-250.

42 Provider Post hearing Brief at 18.

43 Home Health Services of Metropolitan Washington, D.C. v. Office of Direct Reimbursement, HCFA Administrator Dec. July 13, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,089, aff'g PRRB Dec. No. 82-D88 (May 14, 1982), Medicare & Medicaid Guide (CCH) ¶ 31, 986 (Provider's Supplemental Exhibit P- 26F).

The Provider also notes that in Metropolitan, the HCFA Administrator upheld the Board's finding that the use of a retroactive cost limit was invalid. The HCFA Administrator expressly stated:

> [T]he establishment of guidelines for the purpose of applying the substantially out-of-line test in 42 C.F.R. § 405.451(c)(2) is appropriate. However, the application of such guidelines, regardless of how they were developed or by what standards *should not be absolute with respect to a provider's total costs.* Application of such guidelines in this fashion elevates them to the category of "cost limits." Cost limits must meet all the criteria of the regulations at 42 C.F.R. § 405.460.

Id.

The Provider also points out that the use of reasonable cost adjustments as cost limits was also addressed in Home Health Services of Sarasota v. BC/BS of Florida, Inc. ("Sarasota").[44] In that case, the intermediary determined that the provider's overall cost per visit was substantially out-of-line. The intermediary adjusted the provider's total cost by reducing the provider's average cost per visit to the next highest cost per visit. The Board reversed the adjustment to overall costs, stating, "[t]he Board continues to believe that the Intermediary may not apply a cost disallowance to total operating costs under 42 C.F.R. § 405.451(c)(2)." Id. The HCFA Administrator upheld the Board's decision, stating:

> "[u]se of the substantially out-of-line test to place an overall cost limitation on provider costs is inappropriate. This, however, does not interfere with the application of the substantially out-of-line test in 42 C.F.R. § 405.451(c)(2) to specific cost categories or the use of an overall test under this regulation as an indicator that further investigation of the reasonableness of the provider's costs might be warranted."

Sarasota, CCH ¶ 32,459.

Thus, the Provider contends that both the Board and the HCFA Administrator have held that the application of a survey by an intermediary to a provider's total costs is not allowable.

In addition, the Intermediary's witness testified that, as with home health agency cost limits,

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[44] Home Health Services of Sarasota v. BC/BS of Florida, Inc., PRRB Dec. No. 83-D22 (Jan. 5, 1983), Medicare & Medicaid Guide (CCH) ¶ 32,416, aff'd, HCFA Admin. Dec. March 1, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,459 (Provider's Supplemental Exhibits P-26 G & H.

the Intermediary here is "[s]etting a limit of 157 percent of the mean".[45] Specifically, through application of the survey, the Intermediary created a "standard," which was an amount that the Intermediary considered to be a reasonable cost.[46] The Intermediary reimbursed the Provider the "exact amount" that the standard indicated was reasonable.[47]

The Provider defies the Intermediary to explain the distinction between the reasonable cost "standard" applied by the Intermediary and a cost limit. The Provider contends the Intermediary's witness has contradicted his own testimony by indicating that the survey "is applied the same way a cost limit is applied."[48] This is in spite of the fact that the Intermediary has acknowledged that "[w]e have no legal authority to establish a cost limit."[49] It is the Provider's contention that an intermediary-set cost limit masquerading as a survey is illegal.

The Provider recommends that the Board find that the Intermediary has not met its burden of proof that the Provider's costs are substantially out-of-line with the costs of comparable providers, as is required by law, regulation and program instruction. The Provider further recommends that the Board find that the survey is irreparably flawed on its face and is invalid as to content and as applied against this Provider. Further, the Provider recommends that the Board find that the Intermediary functionally sought to create and apply cost limits to the Provider's costs in violation of the law and regulations governing cost limits, and the required notice and comment period. The Provider contends this is beyond the scope of the Intermediary's authority.

INTERMEDIARY'S CONTENTIONS:

The Intermediary explains that a review of the Provider's as filed cost report (Intermediary Exhibit I-23) revealed an unusually high cost per treatment compared to facilities located in the area serviced by the Intermediary. The Intermediary contends that it had requested the Provider to explain the basis for its unusually high costs and the only explanation proffered was an assertion that a high number of denied claims resulted in a disproportionately greater allocation of fixed costs spread over a smaller number of visits. The Intermediary points out that the Provider's average Medicare cost per visit on the as-filed cost report was $170.70, a

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45 Tr. at 209.

46 Tr. at 268.

47 Tr. at 268-269.

48 Tr. at 270.

49 Id.

rate which was almost three times the average of $61.16.[50] Based on a number of factors, including a) evidence that the Provider had removed records about cross-involvement with other companies, b) fraud was already involved on the medical record side of things, and c) lack of a reasonable explanation for an obviously high cost per visit, the Intermediary decided to compare the Provider's costs per visit in the aggregate with those of other outpatient physical therapy providers in the area.[51] The Intermediary's analysis disclosed that the Provider's costs per visit were substantially out of line with those of comparable facilities.[52] The Intermediary explains that it calculated a reasonable cost threshold equal to the average or mean Medicare cost per visit, plus one standard deviation above the mean. The computed threshold was $61.16 plus $34.59 or $95.75 per visit. Applying the $95.75 to the Provider's 13,855 settled Medicare visits, resulted in a disallowance of $897,281.[53]

The Intermediary believes it has complied with all applicable regulations, manual sections, and instructions to demonstrate the Provider's costs were substantially out of line with those of comparable facilities. The Intermediary points to 42 C.F.R. § 413.9(c)(2) which state as follows in pertinent part (Intermediary Exhibit I-12):

> [T]he costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is the subject of a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R. §413.9(c)(2)

In addition, the Intermediary points to the Provider Reimbursement Manual, Part I (HCFA Pub. 15-1), Sections 2102.1 and 2103B.

HCFA Pub. 15-1, §2102.1 also states as follows in pertinent (Intermediary Exhibit I-5):

> [I]mplicit in the intention that actual costs be paid to the extent they are reasonable, is the expectation that the provider seeks to minimize its costs and

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50 Intermediary Position Paper at 22.

51 Tr. 194-196, 234-235.

52 Tr. 193-195; Exhibits I-24 and I-25; see also Intermediary Hearing Chart #2.

53 Intermediary Exhibit I-24.

> that its actual costs do not exceed what a prudent cost-conscious buyer pays for a given item or service (see §2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

HCFA Pub. 15-1, § 2102.1

In addition, HCFA Pub. 15-1, § 2103B states in pertinent part (Intermediary Exhibit I-14):

> [I]ntermediaries may employ various means for detecting and investigating situations in which costs seem excessive.

HCFA Pub. 15-1, § 2103B

The Intermediary explains that it extracted data from 100% of the settled cost reports for outpatient physical therapy providers in Pennsylvania, including all providers serviced by other intermediaries.[54] The Intermediary maintains that since there was no statistical sampling involved, there could be no sampling error.

The Intermediary asserts that because this was a survey of only a narrowly defined type of provider, the facilities in the survey are all comparable in terms of size, geographic location, scope of services, utilization, and other relevant factors. The Intermediary acknowledges that each provider in the survey may not be exactly like the Provider, but contends it does not have to be in order to use a particular provider's results in applying the regulation.[55] The Intermediary points out that the Provider has recognized in its Position Paper that, "Providers need not be similar in all characteristics which affect the costs under evaluation."[56] The Intermediary also points out that its expert also testified that there were no major differences among the providers in the survey.[57]

The Intermediary contends that some of the Provider's efforts to show non-comparability actually work against the Provider. For example, the Intermediary points out that the Provider complained that it was being compared to facilities that are often smaller than the Provider. As the Intermediary's expert witness explained, that should have helped the Provider, because

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54 Tr. 176-180, 260.

55 Intermediary Post Hearing Brief at 6.

56 Provider Position Paper at 20-21.

57 Tr. 197-198.

larger facilities can have economies of scale unavailable to smaller ones.[58] The Intermediary contends that its expert witness in the application of statistical concepts laid bare each and every one of the Provider's statistical concerns, as well as the other points raised by the Provider at the hearing.[59]

The Intermediary explains that using the survey, it originally proposed an adjustment to reduce the Provider's cost per visit from the $170.70 (as filed) and $160.51 (as audited) claimed to $95.75, based on the average in the survey plus one standard deviation. The Intermediary believes that one standard deviation is a reasonable threshold to employ, as it is the same threshold employed for analyzing the reasonableness of home health agency compensation, and it represents an add-on in this case of $34.59, or 57%, of the average cost per visit of $61.16 per visit.[60]

Based on further information adduced at the hearing, the Intermediary now acknowledges the allowable cost per visit should be $110.24, to take into account the area wage differential of 1.1513 for the Philadelphia area where the Provider is located. The Intermediary maintains that since the Provider failed to show any other factors peculiar to itself that would justify its extremely high cost per visit, no additional costs should be allowed.

The Intermediary acknowledges that it 1) has the burden of proof to show that the Provider's costs are substantially out of line, and 2) must survey and identify comparable providers by size, geographic location, scope of services, utilization, and other relevant factors to do so (the Provider's first two contentions).[61] The Intermediary believes it has done exactly that. The Intermediary contends that the Provider has neither shown the Intermediary's survey to be flawed nor produced any other means to compare this Provider's extremely high cost per visit to other providers.[62]

The Intermediary rejects the Provider's contention that a substantially out of line adjustment can only be appropriate for one provider and only then if one is found to be in excess of the highest costs in the range. The Intermediary points out, however, that 42 C.F.R. § 413.9(c)(2) says that an adjustment should be made if a particular institution's costs are substantially out of line "with other institutions." It does not say "with all other institutions," as the Provider would have it. Thus, the Intermediary contends that more than one particular

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58 Tr. 197-203.

59 Tr. at 156-270, Intermediary Post Hearing Brief at 8.

60 Tr. 211.

61 Intermediary Post Hearing Brief at 8.

62 Id.

institution's costs can be substantially out of line with "other institutions." The Intermediary's witness testified that the survey was given to HCFA who in turn gave it to two other area intermediaries and asked them to implement the results of the survey.[63] The Intermediary argues that Medicare's rules for prudence demand no less: if a substantial number of providers can furnish a service for a substantially lower price, then all providers must justify costs over that benchmark or suffer the consequences.

The Intermediary agrees with the Provider that even where one provider's costs exceed the survey's results, its costs may still be allowed if otherwise justified.[64] The Intermediary maintains the survey results were not applied as absolute limits. Id. The Intermediary asserts that the problem is that the Provider did not show factors peculiar to itself that justify the high costs.

Finally, the Intermediary strongly rejects the Provider's contention that substantially out of line determinations may not be used to adjust total costs, only components of costs. The Intermediary contends that the regulation does not specify whether the substantially out of line test is to be applied one way or the other. The Intermediary points out that the regulation at issue, 42 C.F.R
§ 413.9(c)(2), asks the intermediary to review "a particular institution's costs," not "a particular institution's cost categories" or "a particular institution's total costs." The Intermediary contends that under the regulation, comparisons of components of costs or total costs are equally valid.

In summary, the Intermediary asks the Board to affirm its adjustment based on the following reasons:

1. The Intermediary acted in accordance with 42 C.F.R. § 413.9 and HCFA Pub 15-1, §§ 2102.1 and 2103 in determining the Provider's costs.

2. The Provider's average Medicare cost per visit compared to those in the Intermediary's survey data base is so extreme that the Intermediary's adjustment was virtually mandatory. The Intermediary's reasonable cost threshold of one standard deviation above the mean for purposes of its substantially out of line disallowance is liberal and sufficient to accommodate numerous variables which might contribute to expected variations in provider costs.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS

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

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63 Tr. at 180.

64 Intermediary Post Hearing Brief at 9.

§ 1395oo(b) - Board Jurisdiction

2. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A) - Reasonable Cost

3. Regulations - 42 C.F.R:

§ 413.30 (formally § 405.460) - Limitations on Reimbursable Costs

§ 413.9 (formally § 405.451) - Reasonable Cost - Application

§ 405.1835-.1841 - Board Jurisdiction

4. Program Instructions - Part A Intermediary Letter:

I.L. 78-16 -- Medicare Reimbursement -- Evaluation of Reasonableness of Provider Operating Costs

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

§ 2102.1 - Reasonable Costs

§ 2103B - Application of Prudent Buyer Principle

6. Cases:

Girling and Associates Home Health Services, Inc. v. Mutual of Omaha, PRRB Dec. No. 78-D73 (Oct. 31, 1978), Medicare & Medicaid Guide (CCH) ¶ 29,489.

Summit Nursing Home v. Prudential Insurance Company of America, PRRB Dec. No. 88-D29 (Sept. 1, 1988), Medicare & Medicaid Guide (CCH) ¶ 37,408.

Home Health Services of Metropolitan Washington, D.C. v. Office of Direct Reimbursement, HCFA Administrator Dec. July 13, 1982, Medicare & Medicaid Guide (CCH) ¶ 32,089, aff'g, PRRB Dec. No. 82-D88 (May 14, 1982), Medicare & Medicaid Guide (CCH) ¶ 31,986.

Home Health Services of Sarasota v. BC/BS of Florida, Inc., PRRB Dec. No. 83-D22 (Jan. 5, 1983), Medicare & Medicaid Guide (CCH) ¶ 32,416, aff'd, HCFA Admin. Dec. March 1, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,459.

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 the post hearing briefs, makes the following findings of fact and conclusions of law.

Procedural Findings-Motion to Dismiss

The Intermediary filed a motion to dismiss the present case because of its contention that the case should have been filed as a group appeal rather than a single appeal. The Provider in the present case is related to a provider in New Jersey who had also filed appeals related to reasonable cost adjustments. The Intermediary contends that since the parties were related and the issues similar, the fact that all appeals were filed separately rather than as a group is reason for dismissing all appeals. The Provider argued that although a common survey was used to make adjustments to the providers' costs, the underlying arguments for appealing the cases are different.

The Board notes that the statute and regulations require a group appeal to be filed for commonly owned providers where there is any matter involving a common issue. See 42 U.S.C.
§ 1395oo(b) and 42 C.F.R. § 405.1841(a)(2). The Board's Group Appeal Instructions further explain that for an issue to be suitable for a group appeal, the issue must be one in which a single decision by the Board will dispose of the matter for all group participants.

The Board finds that it is clearly evident the group appeal format would not be appropriate because the underlying facts are different for the present case and the New Jersey case, and the Board could not render a single decision applicable to all providers. Therefore, the Board denies the Intermediary's motion to dismiss the cases.

Substantive Findings

The Board finds that the OIG investigation, mentioned in the parties' contentions above, is irrelevant to this case. In determining whether the Intermediary's reasonable cost adjustment to the Provider's costs was proper, the Board felt that three decision areas need to be explained, namely: 1) deciding whether the Intermediary's survey of outpatient therapy providers provided sufficient information to determine if the Provider's costs were substantially out of line with costs of the providers in the survey, 2) determining whether the Intermediary applied the results of the survey to the Provider's total costs as costs limits in making reasonable cost adjustments, and 3) determining whether the Intermediary has met its burden of proof in determining whether the Provider's costs are substantially out of line with comparable providers.

The Board is in agreement that the Intermediary has the burden of proof in determining

whether a provider's costs are substantially out of line with comparable providers. The Intermediary acknowledges this.[65]

The Board believes that the Intermediary met this burden of proof by the fact that it used statewide data of comparable providers in its survey, and treated the data in a statistically valid manner that took into consideration increasing the average cost per visit ($61.16) from the survey providers by one (1) standard deviation or 57 percent to $95.75 per visit. The Board acknowledges the point that there may be deficiencies in the Intermediary's survey, and believes the Intermediary could have provided a better explanation at the hearing on whether the survey took into consideration such items as the manner in which the providers in the survey counted and billed visits, the mix of therapy disciplines in the survey providers, and the consideration of utilization patterns of the geriatric nursing home populations, etc. However, while the Board believes the survey is not without faults, the fact that the Provider's average costs were so much higher ($170.70 vs. $61.16 per visit) than the average cost in the survey led the Board to place great weight on the survey. The Board also believes the Intermediary recognized that the survey was merely a tool for establishing a threshold and not an absolute limit not subject to change. This was evidenced at the hearing when the Intermediary acknowledged that the survey did not take into consideration the wage differential for the Philadelphia area where the Provider is located. The Intermediary agreed that the average cost per visit from the survey plus one (1) standard deviation of $95.75 should be increased by 15.13 percent to $110.24 to take into account the wage differential.[66]

The Board also finds that while the Intermediary has the burden of proving a provider's costs are substantially out of line, the Provider also has a responsibility to document the basis for its costs being significantly greater than the costs of comparable providers. Prior to making a reasonable cost adjustment, the Intermediary asked the Provider for such documentation. The Provider responded by briefly mentioning the high number of speech therapy denials as a contributing factor and indicated that the high costs were temporary in nature.[67] The Intermediary did not consider this an adequate explanation. The Board finds no evidence in the record to conclusively demonstrate unique circumstances that would substantiate the Provider's high costs as compared to those in the survey. Therefore, the Board concurs with the Intermediary that the Provider did not adequately substantiate its high costs as compared to similar providers. Essentially, the Board feels that the Intermediary's survey was adequate evidence to support the Intermediary's action especially in light of the lack of hard evidence from the Provider in support of its case.

The Board finds that the cost adjustment at issue in this case concerns a reasonable cost

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65 Intermediary Post Hearing Brief at 8.

66 Intermediary Post Hearing Brief at 7.

67 Intermediary Exhibit I-25.

determination which the Intermediary properly applied to the Provider's cost report for the period at issue. The Board finds no evidence in the record to support the Provider's contention that the Intermediary exceeded the scope of its authority in creating and applying a cost limit. The Board finds the record is void of any evidence which would support the premise that the Intermediary's survey was authorized and performed under the cost limitation rules and procedures of 42 C.F.R. § 413.30. Accordingly, the Board considers the Intermediary's survey and its application to the Provider's costs as an acceptable method of determining reasonable costs, or "benchmarks" pursuant to the requirements of 42 C.F.R. § 413.9.

The Board also rejects the Provider's contention that substantially out of line determinations may not be used to adjust total costs, only components of costs. The Board refers to the regulation at issue, 42 C.F.R. § 413.9(c)(2) which states in part:

> [T]his is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area.

Id. (emphasis added)

The Board notes that the regulations are not specific as to components of costs or total costs. The Board finds that under the regulation, comparisons of components of costs or total costs are equally valid.

In summary, the Board finds the Intermediary used the best data available to it in making a determination of whether the Provider's costs were substantially out of line when compared to comparable providers. The Board also recognizes that while the survey is not flawless, it contained enough information for the Intermediary to establish a starting point, or if you will, a threshold or "benchmark", and not a limit, when reviewing the Provider's costs for reasonableness. The Board also notes that the Intermediary increased its starting point by 57 percent (one standard deviation) to take into account possible aberrations in the survey instrument. In addition, the Intermediary added another 15 percent on top of this already adjusted threshold to take into account a geographical wage factor. All in all, the Intermediary increased its starting point from $60.16 per visit to an allowable $110.24 per visit or an increase of $50.12 per visit. Even after these two adjustments, the Provider's audited costs per visit were still 46 percent higher, or $160.51 per visit. Based on these facts, the Board finds the Intermediary acted fairly and in accordance with the regulations in making the reasonable cost adjustment.

The Board finds the Intermediary has met its burden of proof that the Provider's costs are substantially out of line with the costs of comparable providers, as required by law, regulation and program instruction. The Board also finds and concludes that while the Intermediary's survey is not flawless, it contained enough information to provide the Intermediary with a starting point in determining if the Provider's costs were substantially out of line with

comparable providers. The Board also believes the Intermediary made significant adjustments to the survey results to compensate for any inherent deficiencies in the survey. Further, the Board finds that the Intermediary did not functionally create and apply cost limits to the Provider's costs in violation of the law and regulations governing cost limits.

DECISION AND ORDER:

The Intermediary's reasonable cost adjustment to the Provider's costs was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

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

Date of Decision: April 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman