PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D50

PROVIDER -Call-A-Nurse, Inc.
St. Louis, Missouri
Belleville, Illinois

DATE OF HEARING-
September 17-19, 1996

Provider Nos. See Appendix I-

vs.

Cost Reporting Period Ended -
January 31, 1991 - January 31, 1993

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

CASE NOS. 94-2093G, 94-2094G, 94-2095G, 96-1323G, 96-1325G

INDEX

ISSUES:

1. Should the Intermediary have applied the exception to the related organizations principal in computing the Provider's reimbursement for the services of Data-Med, Inc, the organization which supplies the data processing and other computer services to the Providers?

2. Was the Intermediary's adjustment to directly allocate salaries proper?

3. Was the Intermediary's disallowance of owners' compensation costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Call-A-Nurse, Inc. is a proprietary corporation headquartered in St. Louis, Missouri.[1] During the fiscal years ending January 1, 1991 and 1992, Call-A-Nurse was a chain organization that operated two separate Medicare certified home health agencies via a home office (Home Office No. 37800) located in St. Louis, Missouri. Provider No. 26-7174 was located in St. Louis, Missouri and Provider No. 14-7477 was located in Belleville, Illinois. Hereinafter, both agencies of Call-A-Nurse, as well as the home office, shall be collectively referred to as "Call-A-Nurse" or the "Provider". For fiscal years 1991 and 1992, the combined agencies worked out of eight branch offices and the Missouri home office. Approximately, 95.5 percent of the Provider's revenues were for services provided to Medicare beneficiaries.

Data-Med Inc. ("Data-Med") is a Medicare data services supplier that, for the fiscal years under appeal, had common ownership with Call-A-Nurse. Data-Med provided billing and data tracking services[2] to many of the home health agencies in the St. Louis area. During fiscal 1991 and 1992, Data-Med had 24 clients (the majority home health agencies) utilizing its services.[3] Call-A-Nurse's Missouri and Illinois agencies constituted two of Data-Med's clients.

Blue Cross and Blue Shield of Iowa (Blue Cross-IA) serves as a Regional Home Health Intermediary under the Medicare program for the Missouri agency and the home office, and is the lead Intermediary in this appeal. Blue Cross and Blue Shield of Illinois (Blue Cross-IL) serves as the fiscal intermediary for the Illinois agency of Call-A-Nurse. Hereinafter, and unless otherwise indicated, both Blue Cross plans will be referred to collectively as the Intermediary.

---

1 Tr. 9/17/96 at p. 9.

2 Tr. 9/17/96 at p. 82.

3 Provider Exhibit 13.

ISSUES IN DISPUTE:

1. Excess Related Organization Costs- For fiscal year 1991, Call-A-Nurse claimed $37,640 for Data-Med's charges to the Missouri and Illinois agencies. Upon audit, the Intermediary made adjustments of $12,589[4] and $9,887,[5] respectively. The Intermediary reduced the Data-Med charges to the actual costs of the billing and tracking services because Data-Med is a related organization to Call-A-Nurse.[6] Additionally, the Intermediary concluded that Call-A-Nurse did not qualify for an exception to the related organizations principle as set forth in 42 C.F.R.
§ 413.17(d).[7] Notices of Program Reimbursement ("NPRs") were issued for Call-A-Nurse on February 10, 1994 and September 20, 1993, respectively.

On March 8, 1994, the Provider filed a timely appeal, challenging the Intermediary denial of reimbursement with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835-.1841 and has met the jurisdictional requirement of those regulations. The Medicare reimbursement effect in dispute is approximately $48,675.[8] The Provider was represented by Charles F. MacKelvie, Esq. of MacKelvie & Associates, and Robert A. Helmer, Esq. of Draheim and Pranschke. The Intermediary was represented by Bernard M. Talbert, Esq. of Blue Cross and Blue Shield Association.

2. Adjustment to Directly Allocate Salaries- Call-A-Nurse claimed a total of $117,721 in salary costs for three employees (non owners), who were also employees of Data- Med (related organization). Those same employees were also paid a total of $29,210 by Data-Med. Upon audit, the Intermediary disallowed $67,764 of the salaries paid to three Call-A-Nurse employees.[9] The Intermediary claimed that the Provider lacked adequate documentation to support the claimed salary expense under 42 C.F.R. § 413.24. As a result, the Intermediary combined the salaries of the three Call-A-Nurse/Data-Med employees and allocated the combined salaries based on the percentage of revenue Data-Med derived from Call-A-Nurse in 1993. NPRs were issued on September 15, 1995 and December 5, 1995, respectively. On March 7, 1996, Call-A-Nurse filed a timely appeal, challenging the Intermediary's denial of reimbursement, with the Board pursuant to 42 C.F.R. § 405.1835-.1841 and has met the

---

4 Intermediary Exhibit I-2

5 Intermediary Exhibit I-2

6 Tr. 9/17/96 at p. 115.

7 Tr. 9/17/96 at p. 117, 119.

8 Intermediary Position Paper of 7/29/96 at 2.

9 Intermediary Position Paper of 8/20/96 at 5-8.

jurisdictional requirement of those regulations. The Medicare reimbursement effect in dispute is approximately $64,764.[10] Representatives are the same for this issue.

3. Disallowance of Owners Compensation Costs- In the as filed Medicare cost reports for fiscal years ended 1/31/91, 1/31/92, and 1/31/93, the Provider claimed total compensation (salary and fringe benefits) for the services of the owners that exceeded an average of $360,000 per year. One of the adjustments made by the Intermediary during each of the three audits was to disallow a portion of Call-A-Nurse's claimed salaries for its owners.[11] The disallowance was based upon a methodology known as the Michigan Survey.[12]

The Provider filed timely appeals for the above mentioned years, challenging the Intermediary's denial of reimbursement pursuant to 42 C.F.R. § 405.1835-.1841 and has met the jurisdictional requirement of those regulations. The Medicare reimbursement effect in dispute is approximately $500,000.[13] Representatives are the same for this issue.

THE HEARINGS:

Call-A-Nurse, Inc. v. Blue Cross and Blue Shield Association (CNs: 94-2093G, 96-1323G, 94-2094G, 94-2095G, and 96-1325G.) The first two cases, case number 94-2093G involving related organization/data processing service, and case number 96-1323G involving the direct allocation of salary were consolidated into one hearing which was held on September 17, 1996. A separate hearing for case numbers 94-2094G, 94-2095G, and 96-1325G, which involved the owners compensation issue, was held on September 18-19, 1996.

ISSUE 1: Exception to Related Organization Principle.

Should the Intermediary have applied the exception to the related organizations principle in computing the Providers' reimbursement for the services of Data-Med Inc., the organization which supplies the data processing and other computer services to the Providers?

PROVIDER'S CONTENTIONS:

The Provider asserts that it satisfied all four requirements of 42 C.F.R. § 413.17(d) which

---

[10] Intermediary Position Paper of 8/20/96 at 4.

[11] Intermediary Position Paper of 8/28/96 at 2.
Intermediary Position Paper of 7/29/96 at 3.
Intermediary Position Paper of 8/20/96 at 4.

[12] Intermediary Position Paper of 8/28/96; Exhibit I-3

[13] Provider Post Hearing Brief at 8.

provides for an exception to the cost to related organizations principle.

The first requirement for receiving an exception to the related organizations principle is described in 42 C.F.R. § 413.17(d)(1)(i) and states that: "[t]he supplying organization is a bona fide separate organization."

The Provider points out that Data-Med is a bona fide separate organization from Call-A-Nurse. Data-Med was incorporated in 1979 as a Missouri business corporation to provide home health agencies with billing and data tracking services.[14] Five years later, in 1983, Call-A-Nurse was incorporated as a Missouri business corporation to provide home health agency services.[15]

The Provider states that both entities have separate checking and payroll accounts and separate financial statements.[16] Both operate their separate businesses from separate offices.[17] During 1991 and 1992 Call-A-Nurse employed three individuals who were also employed, on a part time basis, by Data-Med. However, the Provider asserts that although the Intermediary refers to those employees as "shared employees", the employees were not shared in any manner which would violate the legal separation of corporate finances or activities.[18]

The Provider points out that the employees in question are separately employed and separately paid by the two companies.[19] In addition, the functions performed at Data-Med differed from those performed at Call-A-Nurse.[20]

The Provider contends that the Intermediary has offered no support for its claim that "shared employees" prevent two entities from functioning as bona fide separate corporations. Based on the above, the Provider believes it meets the first requirement of the exception.

The second requirement for receiving an exception to the related organizations principle is described in 42 C.F.R. § 413.17(d)(1)(ii) which provides in part: "[A] substantial part of the supplying organization's business activity of the type carried on with the provider is

---

14 Tr. 9/17/96 at p. 9.

15 Tr. 9/17/96 at p. 9.

16 Tr. 9/17/96 at p. 40

17 Tr. 9/17/96 at p. 37.

18 Tr. 9/17/96 at p. 88-90

19 Tr. 9/17/96 at p. 154.

20 Tr. 9/17/96 at p. 52

transacted with other organizations not related to the provider and the supplier by common ownership or control."

The Provider contends that the manner in which the Intermediary applied the "substantial business test" is not in accordance with the regulations. Specifically, the Intermediary incorrectly focused on whether a substantial part of the Provider's business is transacted with Data-Med. The Provider asserts that the plain meaning in 42 C.F.R. § 413.17 states that a substantial amount of the supplying organizations business must be transacted with other Providers. As the Intermediary admitted, Data-Med transacted a substantial amount of its business with other providers.[21] Data-Med received over 68% of its 1991 revenue from Providers other than Call-A-Nurse, and over 63% of its 1992 revenue from Providers other than Call-A-Nurse.[22]

The Provider also contends that the Intermediary was arbitrary in establishing a 10% rule, which mandated that 90% of the related organizations business must be conducted with non-related entities in order to qualify for the exception. The Provider believes that the 10% test is inconsistent with the decision of the Board in the Tip of Illinois Health Services, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 93-D29, March 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,354.[23] In that case, the Board explained that the facts in Tip of Illinois were consistent with the clarifying language and example 1 in HCFA Pub. 15-1, 1010.1.

> "[t]he exception is intended to cover situations where large quantities of goods and services are provided to the general public and only incidentally are furnished to related organizations."

Id.

The HCFA Administrator upheld the Board decision concluding that: 63% and 53% of the services furnished to the general public are considered to be substantial portions of business. Thus, the Provider concludes that a substantial portion of Data-Med's business is conducted with non-related entities, and the second exception is met.

The third requirement for receiving an exception to the related organizations principle is described in 42 C.F.R. § 413.17(d)(1)(iii) and states: "[t]he services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other

---

21 Tr. 9/17/96 at p. 135.

22 Tr. 9/17/96 at p. 48,84.

23 PRRB Hearing Decision No. 93-D29

organizations and are not a basic element of patient care ordinarily furnished to patients by such institutions." Id.

The Provider contends that Data-Med's client list constitutes a substantial portion of the home health care community in the Missouri area.[24] Therefore, Data-Med's services are commonly obtained by home health agencies from an outside organization.

The Provider also contends that the billing and data processing services are not a basic element of patient care ordinarily furnished directly to patients by home health agencies.[25] The Provider believes that, based on the above facts, the third requirement for an exception has been met.

The fourth requirement for receiving an exception to the related organizations principle is contained in 42 C.F.R. § 413.17(d)(1)(iv) and states: "[t]he charge to the Provider is in line with the charge for such services, facilities,or supplies in the open market, and no more than the charge made under comparable circumstances to others by the organization for such services."

The Provider contends that Data-Med's dealings with its other customers in Missouri were at arms length, so the prices for Data-Med's services constitute a discernible price in the open market. Accordingly, the price Data-Med charged Call-A-Nurse for its billing and tracking services was in line with market prices for these services.[26]

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the audit adjustments which reduced charges made by a related organization to the actual cost to the related organization were made in accordance with 42 C.F.R. § 413.17- Cost to Related Organizations and HCFA-Pub. 15-1, Chapter 10- Cost to Related Organizations. The Intermediary also points out that the related organization's accounting records do not meet the adequacy of cost information requirements as set forth in
42 C.F.R. § 413.20 and 42 C.F.R. § 413.24. In this case, the Provider and Data-Med are owned and controlled by the same two individuals. The Intermediary reviewed salaries and wages of Data-Med, Inc. and determined that the salaries consisted of three employees who share their services between Data-Med and the Provider. It was determined upon audit that the documentation in support of the assignment of salaries to these two corporations was based on unauditable estimates.

---

[24] Provider Exhibit 13

[25] Tr. 9/17/96 at p. 91.

[26] Tr. 9/17/96 at p. 92.

The Intermediary points out that it would have been justified in disallowing 100 percent of the charges to the Provider. However, the Intermediary chose the less punitive adjustment and adjusted charges to what appears to be an understated Data-Med cost figure.

The Intermediary contends that the Provider is not entitled to an exception to the related organization cost principle because the criteria under 42 C.F.R. § 413.17(d)(1)(i) was not met. Data-Med, Inc. is not a bona fide separate organization as required by the regulation. It is separate in name only, and in reality operates as a division of Call-A-Nurse (the Provider). The services provided to Call-A-Nurse by Data-Med are sometimes obtained by providers from other organizations but are more commonly provided in-house. In the case of Data-Med and Call-A-Nurse, the Data-Med employees providing these services are also Call-A-Nurse employees. Thus, the services could easily be provided in-house. The Intermediary reasons that it is not prudent for the Provider to re-hire these same employees via Data-Med and then pay a marked up price for their services.

The Intermediary contends that the Provider is not entitled to an exception to the related organizations principle since the requirement of 42 C.F.R. § 413.17(d)(1)(ii) also was not met. That section reads in part: "[a] substantial part of its business activity. . . is transacted with other than the Provider and organizations related to the supplier." Id. An analysis of the volume of services rendered to the Provider by Data-Med reflects a substantial business activity and is not incidental, as intended by the regulations.[27]

The Intermediary also points to correspondence from HCFA to the Provider, the purpose of which was to determine whether the Intermediary had properly applied HCFA Pub. 15-1, Sections 1010.b and 1010.d.[28] HCFA concluded that since the related organization charged the Provider substantially less than it charged the general public, the requirements in Sections 1010.b and 1010.d were not met.

ISSUE 2: Adjustment to directly allocate salaries.

Was the Intermediary adjustment to directly allocate salaries proper?

PROVIDER'S CONTENTIONS:

The Provider contends that its employees maintained adequate time records to verify the correct amount of Medicare program payments. As of the date of the hearing, the Provider asserts that no regulation specifically addressed the adequacy of employee time records.[29]

---

[27] Intermediary Position Paper at 6.

[28] Intermediary Exhibit I-4.

[29] Tr. 9/17/96 at p. 209.

Instead, the various provider agencies have relied upon the regional intermediaries to offer guidance in this area.[30] In the absence of more specific guidance, the general language in 42 C.F.R. §§ 413.20 and 413.24 sets forth the documentation requirements concerning general financial and statistical documentation. Section 413.20 provides in relevant part that providers are to maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Section 413.24 addresses the adequacy of cost data by stating in part: "[p]roviders receiving payment on the basis of reimbursable costs must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by independent auditors." Id.

Section 2304 of the PRM also sets forth guidance on adequate cost information. Specifically, section 2304 states: "[c]ost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries". Id.

The Provider contends that despite the general language set forth in the regulations and the general instructions, there continues to be much confusion concerning the extent to which certain documentation must be detailed to satisfy the requirements set forth in the regulations. For example, 42 C.F.R. § 413.20 does not require changes in widely accepted reporting practices to determine costs payable under the principles of reimbursement. Rather, the Intermediary is instructed to make use of data available from the institutions basic accounts.

The Provider asserts that the Intermediary's policy on maintaining employee time records is not in accordance with the regulations noted above. In May of 1989, the Intermediary circulated a special edition of its Medicare Info letter.[31] The subject of that letter was a clarification of the requirement and use of periodic and continuous (100%) time studies to properly allocate costs on the Medicare cost report which referenced PRM § 2313.2E. According to that letter, the Intermediary recommended that a provider maintain continuous 100% time studies for employees whose salaries are split among more than one discipline (i.e., when the total salary claimed is split among more than one discipline.) Thus, the Medicare Info letter set forth the Intermediary's requirement that continuous rather than periodic time studies were to be used in these situations.[32] In that letter, the Intermediary also set forth the specificity of the information to be included in the time study.

However, the letter specifically stated that a time study is not needed if the employee at issue does not perform work in more than one cost center.

---

30 Id at p. 158-159.

31 Provider Exhibit 9.

32 Id

The Medicare letter clarified the requirement that adequate documentation is necessary to evidence a split in salary between more than one cost center. The Intermediary's letter did not specify any additional time keeping requirements for employees whose salaries are not split among different cost centers, or for employees that work for a related organization.[33] The Medicare letter was the only guidance offered to the Provider regarding the specificity of the employee time records prior to the 1993 fiscal year.[34]

Six months after the close of the 1993 fiscal year, the Provider received a July 16, 1993 recommendation letter concerning the Provider's time records for its three employees.[35] The letter was based upon recommendations arising from the Intermediary's audit of the Provider's 1992 cost report.[36] However, the Intermediary's recommendation came too late for the Provider to apply in its 1993 fiscal year cost report. The Provider asserts that retroactive application is prohibited whether the rule is legislative or interpretive. Health Insurance Association of America v. Shalala, 23 F. 3d 412, 422 (D.C. Cir. 1994); Bowen v. Georgetown University Hospital,488 U.S. 204 (1988); and Minnesota Hospital Association v. Bowen, 703 F. Supp. 780 (D. Minn. 1988).

The Provider contends that for fiscal year 1993, Call-A-Nurse submitted employee time records to the Intermediary that were adequate for the intended purpose and consistent with industry practice regarding employee time records.[37] Moreover, the employee time records were consistent with 42 C.F.R. §§ 413.20. The employee time records were completed on a daily basis and evidenced the actual time spent working between Data-Med and Call-A-Nurse.[38] The time records are capable of being audited and can be verified by the Provider's payroll records and the W-2 forms.[39]

The Provider contends that the time records maintained by its employees met the requirements of 42 C.F.R. §§ 413.20 and 413.24. Specifically, one employee testified that she maintained daily time records of the actual hours worked for both Call-A-Nurse and Data-

---

33 Tr. 9/17/96 at p. 157-158.

34 Id at p. 158-159.

35 Tr. 9/17/96 at p. 216.

36 Provider Exhibit

37 Provider Exhibit 6.

38 Tr. 9/17/96 at p. 184-185.

39 Provider Exhibits 4, 5, and 13.

Med.[40] For example, her testimony indicated that she recorded the time she arrived and the time she left work each day in the daily log. She also recorded the number of hours she spent working for Data-Med in the daily log.[41] The time sheets can be verified with each employee's W-2 forms, and corresponding payroll records.[42]

The Provider also maintains that the time records maintained by another shared employee met the requirements of 42 C.F.R. §§ 413.20 and 413.24. However, these time records were challenged by the Intermediary as unreliable.[43] The Intermediary's rationale for its adjustment is based on four telephone records created by the Intermediary.[44] The Intermediary's reliance on the telephone records is both misleading and inaccurate in that the telephone records merely reflect that its employee spoke with Intermediary auditors on four separate occasions.[45]

In response to questions from the Provider concerning the four 1993 telephone records, the Intermediary verified that no other documentation was available to support its claim that an employee worked on Data-Med clients during his Call-A-Nurse work hours.[46]

As a salaried employee of Call-A-Nurse and based on the Intermediary's letter, the Provider contends that its employee was not required to keep the detailed time records that are now required by the Intermediaries.[47] The applicable sections of Medicare law do not require, and have never required, the Provider to maintain more specific time records than they maintained in fiscal year 1993.[48]

The Provider contends that the Intermediary did not adequately communicate its documentation requirements. According to the Intermediary, the time records were not sufficient because the employees did not specify what job functions they were performing

---

40 Tr. 9/17/96 at p. 172.

41 Id at p. 174.

42 Provider Exhibits 4, 5, and 13.

43 Tr. 9/17/96 at p. 200-201.

44 Id at p. 201, 210-211.

45 Tr. 9/17/96 at p. 201,211.

46 Id at p. 211.

47 Id at p. 158.

48 Id at p. 160.

each day.[49] However, as the Medicare Info letter demonstrates, there was no requirement that they maintain time studies if the salaries are claimed entirely in the administrative and general cost center.[50] Indeed, the Provider's employees had maintained similar time records through the 1993 fiscal year, and the Intermediary had always allowed the employees salary costs.

The Provider contends that the recompiled time records sufficiently document the employee's time and comply with the adequate documentation requirements of the Medicare regulations. In an attempt to comply with the July 16, 1993 recommendation letter, the Provider's employees recompiled their time sheets to provide the Intermediary with a more detailed description of their activities.[51] The recompiled time records for fiscal year 1993 were prepared well in advance of the exit conference on March 31, 1994, and made available to the Intermediary.[52]

The recompiled time records were created using the original time records and corresponding documents to accurately restate the employee's time. The Provider's recompiled records specify the type of work performed for Call-A-Nurse, for example, "payroll," "billing," "filing," etc., and date and hours spent performing these functions. In addition, the records specify the total hours spent each work day for Call-A-Nurse.[53]

In spite of the Provider's attempt to comply with the Intermediary's untimely request for more detailed time records, the Intermediary now claims that the recompiled records fail to comply with the adequate documentation requirement in 42 C.F.R. § 413.20.[54] According to the Intermediary's the recompiled time records did not provide an adequate detailed description of the employees job function.[55]

The Provider believes the Intermediary's rationale is unjustified for two reasons. First, Call-A-Nurse's time records only contain billing activity performed by and for Call-A-Nurse.

---

49 Id at p. 203, 213.

50 Provider Exhibit 9.

51 Provider Exhibit 11.

52 Tr. 9/17/96 at p. 176,186.

53 Provider Exhibit 11.

54 Tr. 9/17/97 at p. 216-217.

55 Tr. 9/17/96 at p. 205, 213.

Moreover, the Data-Med time records specify when the employees performed work for Call-A-Nurse.[56]

Second, the Intermediary's auditors never interviewed the individual employees to ascertain exactly what services were being performed by Data-Med. Thus, the Intermediary did not fully understand the distinction in activities performed by the employees for both Call-A-Nurse and Data-Med.[57]

The Provider contends that detailed time records are not required to determine allowable costs. It cites In Home Health v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa and Illinois and Blue Cross and Blue Shield of Wisconsin, PRRB Decision No. 96-D36, June 10, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,477, and the HCFA Administrator decision In Mother Francis Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Texas, PRRB Decision No. 95-D16, January 11, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,037, rev'd HCFA Admin. February 8, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,241. Both decisions stated that detailed time records are not needed to determine the amount of allowable costs.

The Provider contends that the following HCFA decisions also hold that a provider is not required to keep the level of documentation being required by the Intermediary. In VNA of Greater St. Louis, St. Louis, Missouri v. Blue Cross Health Services, Inc., of St. Louis, Missouri (PRRB Case No. 86-D47), December 31, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,467, the intermediary disallowed 100 percent of the costs of nurses employed as so-called "Continuing Care Consultants". The Consultants' costs were regularly reimbursed until 1982 and, as a result, VNA had not maintained detailed records of its Consultants' activities. The intermediary then disallowed 100% of the costs of these activities for 1978, 1979 and 1980, even though it agreed that some of the activities were allowable, because (as characterized by the Board) "the actual time spent on any of the activities which might be characterized as allowable cannot be determined by any practical means". Id.

The Board reversed the adjustments finding that a document created in 1983, based upon the recollections of the Consultants who had been employed during the years at issue, summarized their activities and allotted percentages of time to each activity reliably documented the consultants'activities In 1978, 1979 and 1980. Id.

In Eden Home Care v. Blue Cross & Blue Shield Association/Blue Cross of California (PRRB Case No. 92-D9), February 7, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,013, the final decision of the Board was that despite the fact that the Provider did not keep detailed time

---

[56] Provider Exhibit 11-73.

[57] Tr. 9/17/96 at p. 207.

records of its employees, the activities were 100 percent allowable based upon their job descriptions and total amount of time necessary to complete those duties. In the instant case, similar to Eden, the Providers have submitted their job descriptions, adequate time sheets and an abundance of other documentary evidence demonstrating what functions the employees performed.[58]

Finally, in Shalala v. St. Paul-Ramsey Medical Center, 50 F.3 d 522 (8th Cir. 1995), the court rejected the Secretary's determination that St. Paul failed to comply with the documentation requirement under section 312(D) of the PRM, and therefore, failed to comply with 42 C.F.R. §§ 413.20 and 413.24. Id.

Alternatively, the Provider argues that if the Board determines that the documentation is inadequate to support the Provider's claimed costs, the methodology utilized by the Intermediary is improper. Citing Tampa Gulf Coast Home Health Care, Inc. v. Ætna Life Insurance Company of America, PRRB Decision No. 94-D3, November 10, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,940, the Provider asserts that the percentages to be allocated to the companies should be based on the total revenue of each company.[59] This contrasts with the Intermediary's allocation of compensation based on the percentage of Data-Med revenue from Call-A-Nurse.[60]

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position, after reviewing time studies submitted by the Provider, that the assigned salaries of the three employees who are shared by Data-Med and Call-A-Nurse were based on unauditable estimates. This resulted in an understatement of Data-Med's salaries with the effect of overstating the salaries assigned to Call-A-Nurse.

The Intermediary refers to 42 C.F.R. § 413.24 which states in part "[a]dequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization." Id.

The Intermediary contends that Call-A-Nurse time studies merely indicate the amount of time spent on activities for each company and do not describe the activities themselves. Merely

---

58 Provider Exhibits 5, 6, 11, 12, & 13.

59 Provider's Post hearing Brief at p. 39.

60 Id at p. 38.

indicating beginning and ending times is not acceptable because of the potential for cost shifting between the Provider and the related company.

The Intermediary contends that its time keeping policy, specific to the Provider's circumstances, has been communicated to the Provider through formal recommendation letters.[61] It is the Intermediary's position that it is necessary for employees shared between the Medicare reimbursable Call-A-Nurse agencies and the nonreimbursable companies related to the Provider to keep continuous time records to support the split of salaries between the related companies. Without descriptive time records, the Intermediary is unable to ensure that Medicare is reimbursing Call-A-Nurse for employee activities related only to the Medicare program.

The Intermediary further asserts that it discussed the issues of time studies and the allocation of salaries during the field audit of the fiscal year 1993 Medicare cost report, as well as the March 31, 1994 exit conference.

The Intermediary contends that the Provider's proposed methodology to allocate salary costs based on the revenues of the two companies is incorrect. It is not reasonable or appropriate to use the revenue ratio as it does not properly match revenues. Call-A-Nurse revenues include health care services, while Data-Med revenue consists of data processing services.

ISSUE 3 - Disallowance of Owner's Compensation Costs.

Was the Intermediary's disallowance of owners compensation costs proper?

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary did not utilize a proper methodology to ascertain reasonable compensation for the Provider's executives. The Provider cites 42 C.F.R. § 413.102 which states in part "[a] reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function. . . . Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions; or it may be determined by other appropriate means." Id. The Provider also refers to the Provider Reimbursement Manual (Part 1) ("PRM"-1) § 904 which states "[i]ntermediaries have the responsibility for evaluating the reasonableness of an owner's compensation. . . On the basis of information obtained by surveys of provider, ranges of compensation for comparable institutions will be established. Intermediaries will utilize these ranges both for final settlement and when setting interim rates." Id.

The Provider asserts that the Intermediary failed to comply with the regulation noted above, in

---

[61] Intermediary Exhibit I-7.

that the Intermediary did not conduct a survey of agencies in the St. Louis area,[62] nor did it evaluate the duties and responsibilities of the owners and contrast them with those of their peers.[63]

The Provider contends that the use of the Michigan Survey/Method ("Michigan Survey") by the Intermediary is not an appropriate alternative method for evaluating administrative salaries. The Michigan Survey was developed in 1979 by Blue Cross and Blue Shield of Michigan to measure outpatient physical therapy agency owner/administrator compensation. Since the Intermediary did not perform a survey of home office providers, it deferred to HCFA Pub. 15-1, Section 905.5 as the justification for utilizing the Michigan Survey.[64] The Intermediary rationale was that Section 905.5 allows the use of other compensation surveys when there are few similar providers in the area. The Provider asserts that the Michigan Survey only consisted of 16 agencies and that the Intermediary has no knowledge of whether the agencies in the survey vary significantly in size, complexity and scope with the Provider.[65]

The Provider contends that the PRRB has consistently disapproved of the use of inaccurate data to limit owner's compensation. In Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc., PRRB Decision No. 88-D30, September 2, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,439, the Board stated "[t]hat the Intermediary did not demonstrate, pursuant to 42 C.F.R. § 405.451(c)(2), that the administrator's compensation was substantially out of line with the costs incurred by other HHAs in the same area which are similar in size, scope of services, utilization, and other relevant factors. Likewise, in El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Texas, PRRB Decision 89-D2, November 3, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,505, the board stated that "[t]he Intermediary's use of the Denver Regional Office's survey [to adjust a Texas provider's salaries] is inappropriate because the provider is from a different area." Id.

The Provider argues that the Intermediary has ignored other survey data that more accurately reflects owner's compensation in the greater St. Louis area. For example, as part of the Intermediary's discovery response to two previous provider appeals concerning owner's compensation adjustments, the Intermediary produced a survey of several St. Louis area providers.[66] Upon review, Call-A-Nurse's compensation for this Administrator was

---

62 Tr. 9/19/96 at p. 156.

63 Id at p. 147-148.

64 Intermediary Position Paper FYE 1/31/93 at p. 8-9.

65 Tr. 9/19/96 at p. 140-142.

66 Provider's FYE 1/31/93 Exhibit 11.

comparable to, and not out of line with, compensation of an administrator in the St. Louis area. In addition to the St. Louis survey, the Provider has submitted the compensation analysis of Dr. Randall Dunham to support the reasonableness of the executive's salaries.[67] The Provider notes that in Stat Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Decision 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,011, the Board concluded that a provider's claimed compensation should be allowed when the Intermediary does not use proper survey data and ignores other survey data in the record to limit the owner's compensation. Id.

The Provider contends that the Intermediary's methodology is statistically invalid based on the following:

1. The methodology imposes a compensation cap set at the "maximum" allowable compensation from the chart. This is not in accordance with 42 C.F.R. § 413.9 which requires payment of reasonable compensation which is not out of line with compensation paid by other providers.

2. The methodology fails to account for the Provider's relative size, scope of services, utilization, and other relevant factors as required by 42 C.F.R. § 413.9. Call-A-Nurse total visits increased from 61,289 in fiscal year 1/31/91 to 98,553 visits in fiscal year 1/31/93.

3. The Intermediary's compensation ranges show yearly adjustment factors based on a HCFA mandate estimating increases in the consumer price index, which is unrelated to actual health care inflation figures.[68]

4. The Intermediary's scoring of its questionnaire was incorrect and resulted in skewed allowable compensation calculations.[69]

The Provider further contends that the claimed compensation for both the Chief Executive Officer and the Executive Director was reasonable for the fiscal years at issue. Dr. Randall Dunham, an expert on executive compensation in the health care industry, was engaged by the Provider to perform an independent evaluation of the reasonableness of the Provider's owner's compensation for fiscal years 1991,1992, and 1993. Dr. Dunham's methodology was

---

[67] Tr. 9/19/96 at p. 49-53
Provider's FYEs 1/31/91 and 1/31/92 Exhibit 13.
Provider's FYE 1/31/93 Exhibit 14.

[68] Provider's FYE 1/31/93 Exhibit 21.

[69] Provider's FYE 1/31/92 Exhibit 1-18.

set forth in detail during the September 18 and 19, 1996 Board hearing.[70] According to Dr. Dunham's evaluation, reasonable compensation for the Provider's executives was substantially higher than the Intermediary's findings,which were developed using the Michigan Survey.[71]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its test of reasonableness was based on 42 C.F.R. § 413.102(c)(2) which states "[r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means." Id. In that there are no compensation surveys of top level executive positions in the home office of a chain organization, the Intermediary believes that the application of HCFA Publication 15, Part 1, § 905.5 - Few Similar Providers in an Area, is justified.

The Intermediary contends that the Michigan Survey is a valid analytical tool for determining the reasonableness of compensation. This survey/method was developed by Blue Cross and Blue Shield of Michigan and is based on a survey of home health agencies located in large metropolitan areas in Michigan. The Board has repeatedly accepted the Michigan Survey/Method as a valid method for determining reasonableness; most recently in Ruston Physical Therapy and Rehabilitation Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Louisiana, PRRB Decision No. 91-D3, October 25, 1990, Medicare & Medicaid Guide (CCH)
¶ 38,933. The methods and procedures used in the Michigan Survey clearly give consideration to key factors used to determine reasonableness such as education, experience, agency volume, job duties, and geographical location.[72]

The Intermediary further contends that its calculation is accurate and without bias to the Provider. For example, salaries in the Michigan Survey are higher than salaries in the Provider's area (St. Louis, MO). However, no adjustment was made for this differential. Secondly, patient visits were factored into the Michigan calculation so that it recognizes higher levels of compensation for the larger organizations.

---

70 Tr. 9/19/96 at p. 10-46.

71 Provider's Post Hearing Brief at p. 37-38.

72 Intermediary Position Paper p. 10-14.

The Intermediary contends that its determination using the Michigan Survey methodology reflects the following reasonable total compensation levels (salary and fringe benefits):

	CEO	Exec. Director
FYE		
1/31/91	$ 96,475	$89,555
1/31/92	100,623	93,407
1/31/93	106,384	97,972

The Intermediary contends that it corroborated its results by comparing the Michigan Survey to a survey of Missouri home health agency salaries. The results show that the Michigan method is valid, and conservatively overstates the compensation level.[73] This was supplemented by another comparison of the Michigan Survey to the National Association for Home Care Home Health Agency Compensation Survey. Again, it is the Intermediary's position that the Michigan Survey generously overstates reasonable compensation.[74]

The Intermediary also contends that the Provider has not submitted documentation in support of the reasonableness of the owner's compensation. To the Intermediary's knowledge, the Provider did not maintain auditable time records to support total hours of services rendered by the owners on site at the home health agencies.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws:

42 U.S.C. § 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 405.451(c)(2) (redesignated) 413.9	-	Cost Related to Patient Care
§ 405.1835-.1841	-	Board Jurisdiction
§ 413.17	-	Cost to Related Organizations
§ 413.20	-	Financial Data and Reports

---

[73] Intermediary Exhibit I-6.

[74] Intermediary Exhibit !-7.

§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.9	-	Research Costs
§ 413.102	-	Compensation of Owners

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

§ 312.D	-	Indigent or Medically Indigent Patients
§ 904	-	Criteria for Determining Reasonable Compensation
§ 905.5	-	Procedures for Determining Reasonable Compensation
§ 1000	-	Cost to Related Organizations Principle
§ 1010	-	Exception to the Related Organization Principle
§ 1010.1	-	Examples of Applying the Exception
§ 2304	-	Adequacy of Cost Information
§ 2312.2E	-	Periodic Time Studies

4. Case Law:

TIP of Illinois Health Services, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 93-D29, March 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,354, aff'd HCFA Admin. May 5, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,464.

Health Insurance Association of America, Inc., v. Shalala, 23 F.3d 412, 422 (D.C. Cir. 1994).

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

Minnesota Hospital Association v. Bowen, 703 F. Supp. 780 (D. Minn. 1988).

In Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Iowa, Blue Cross and Blue Shield of Illinois, and Blue Cross and Blue Shield of Wisconsin, PRRB Dec. No. 96-D36, June 10, 1996, Medicare & Medicaid Guide (CCH)
¶ 44,477, modified in part, aff'd in part HCFA Admin., August 4, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,594.

Mother Francis Hospital v. Blue Cross and Blue Shield of Texas, PRRB Hearing Dec. No. 95-D16, January 11, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,037, Rev. HCFA Adm. February 8, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,241.

VNA of Greater St. Louis, St. Louis, Missouri v. Blue Cross Health Services, Inc. of St. Louis, Missouri, PRRB Dec No. 86-D47, December 31, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,467, declined rev., HCFA Admin. February 20, 1996.

Eden Hospital Home Care v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 92-D9, February 7, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,013, declined rev., HCFA Admin. March 16, 1992.

Shalala v. St. Paul-Ramsey Medical Center, 50 F.3d 522 (8th Cir. 1995).

Tampa Gulf Coast Home Health Care, Inc. v Ætna Life Insurance Company of America, PRRB Dec. No. 94-D3, November 10, 1993, Medicare & Medicaid Guide (CCH)
¶ 41,940, declined rev., HCFA Admin. December 28, 1993.

Alexander's Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 98D-30, September 2, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,439, aff'd HCFA Admin., October 31, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,504.

El Paso Nurses Unlimited, Inc. v. Blue Cross and Blue Shield of Texas, PRRB Dec. No. 89-D2, November 3, 1988, Medicare & Medicaid Guide (CCH) ¶ 37,505, declined rev., HCFA Admin. December 6, 1988.

Stat Home Health Care, Inc. (Los Angeles, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 96-D7, January 30, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,011, declined rev., March 15, 1996.

Ruston Physical Therapy and Rehabilitation Agency v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D3, October 25, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,933, declined rev., HCFA Admin. December 6, 1990.

Health Central Inc. Group v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 78-D40, June 9, 1978, Medicare & Medicaid Guide (CCH) ¶ 29,204, declined rev., August 7, 1978.

5. Other:

Michigan Blue Cross OPT Owner's Compensation Guidelines.

The Missouri Alliance for Home Care 1992 MACH Home Care Salary Survey.

The National Association for Home Care Home Health Agency Compensation Survey

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after considering the facts of the case, parties' contentions, testimony and evidence submitted, finds and concludes as follows:

Issue 1- Exception To Related Organization Principle:

The Board recognizes that 42 C.F.R § 413.17 states that if a Medicare provider purchases services from a related organization, those costs will only be reimbursed to the provider at the cost of the related organization. Section 413.17 also contains an exception provision which allows a provider to be reimbursed to the extent of supplier charges, provided four specific criteria are met.

The majority of the Board finds that the Provider is not entitled to an exception to the related organization principle as it did not meet the criteria of 42 C.F.R. § 413.17 (d)(1)(ii). This section of the regulations reads in part: "[a] substantial part of its business activity. . . . is transacted with other than the Provider and organizations related to the supplier." Id.

The majority of the Board finds that the Provider's reliance on the previous PRRB decision No. 93-D29 in Tip of Illinois is not relevant to the instant case. In Tip of Illinois, the services in question were purchased by the general public, not by other providers. In the instant case, the record indicates that the Provider accounts for approximately 34 percent of the total revenue of Data-Med, the related organization. In addition, the Data-Med profit margin in fiscal year 1993 was approximately 209% prior to application of the Intermediaries adjustment. After the Intermediary's adjustments, the Data-Med profit margin was only 14%.

The Board majority noted that the HCFA Administrator, in reviewing Tip of Illinois, referenced a case entitled Health Central Inc. Group v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Decision No. 78-D40, June 9, 978, Medicare & Medicaid Guide (CCH) ¶ 29,204. In that case, the Intermediary denied an exception to the related organizations principle where the related organization furnished a substantial portion (40 percent) of its services to the related Provider, but also furnished the same services to its own clients. Based on the similar fact patterns in Health Central Inc. and the instant case, the Board majority does not believe the Tip of Illinois case to be controlling.

The Board majority notes that neither the regulations nor the Medicare program instructions specify a particular standard of measurement for defining the term "substantial part" as used in the regulation referenced above. Since there are no defined rules, the determination as to whether a particular set of facts qualifies for the exception is judgmental.

The Board majority finds that the Medicare program instructions in the Provider Reimbursement Manual ("HCFA Pub. 15-1") § 1000 clarify the Cost To Related Organizations regulation (42 C.F.R. § 413.17) by stating in part: "[t]he purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's length bargaining." Id. Also, HCFA Pub. 15-1 § 1010.1 entitled Examples of Applying the Exception states: "[t]he exception is intended to cover situations where large quantities of goods and services are supplied to the general public and only incidentally are furnished to related organizations." Id. (Emphasis added.)

Based on the above, the Board majority finds that the Provider's argument is without merit and that the Provider is not entitled to an exception to the Cost To Related Organizations regulation in 42 C.F.R. § 413.17.

Issue 2 - Adjustment to Directly Allocate Salaries:

The Provider argues that the Intermediary improperly applied the related organization principle in disallowing salary costs of three of the Provider's employees who are also shared with Data-Med, a related organization. Secondly, the Provider states that it adequately documented its employee's time for reimbursement purposes.

The Board majority finds that, as noted in Issue 1 above, the Provider is not entitled to an exception to the Cost To Related Organizations regulation. Therefore, the Intermediary's action to reallocate a portion of the Provider's salary costs was proper within the criteria of 42 C.F.R.
§ 413.17.

The Board majority finds that the Provider's argument regarding the adequacy of its payroll

records is without merit. Regulation 42 C.F.R. § 413.24(c) states in part: "[a]dequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended." Id. (Emphasis added.)

The Board majority recognizes that nothing in the Regulations requires a provider to maintain a continuous time study. However, the record indicates that the Provider's payroll records were non-contemporaneous and did not clearly separate the specific work activities performed on behalf of the Provider, as well as Data-Med.

The Board majority finds that following the 1/31/92 audit, the Provider was requested to keep adequate and auditable time records for proper allocation of salaries between organizations. There was a subsequent reconstruction of payroll records by the Provider. However, the Board majority finds that the revised records were inadequate in that only the amount of time spent was identified. Lacking was the critical information as to the specific activities performed.

Issue 3 - Disallowance of Owners' Compensation Costs:

The Board finds that the Intermediary's disallowance of a portion of the owners' compensation is improper, in that the means by which the Intermediary determined the "reasonableness" of the compensation at issue was inappropriate.

Medicare regulation 42 C.F.R. § 413.102 explains that the reasonablness of compensation paid to the owner of a health care organization may be determined by comparing it to the compensation paid for like services performed in comparable institutions or by "other appropriate means." Program instructions at HCFA Pub. 15-1 § 904.1 provide factors which are to be considered in determining the comparability of institutions. These factors include, but are not limited to, the size of the organization, its classification by type and range of services provided, personnel employed, and geographical location.

The Intermediary concluded that there are no compensation surveys of key employees in the home office of a chain organization that can be used to determine the reasonableness of the Provider's owners' compensation. As a substitute, the Intermediary utilized the Michigan Survey. This is a composit of data obtained in 1979 from 16 facilities located in the Michigan area.

The Board finds that it must judge the quality of the salary evidence and rely on the best evidence presented. In the instant case, the Michigan survey does not produce results that are representative of the Provider's organization and, therefore, cannot serve as the basis for a cost disallowance. The Board finds there is no assurance that the compensation data contained in the Michigan Survey is representative of the compensation levels paid by health

care organizations in the Provider's geographical location. In addition, the Michigan Survey was designed for OPT owner/administrators rather than home health agency owner/administrators. There is a significant difference in the range of services performed by these two different provider types, the types of personnel employed, and the other criteria set forth in HCFA Pub. 15-1 § 904.1.

The Board rejects the Intermediary's contention that its determination is corroborated by other studies. The Board finds that the data used in the Missouri Alliance for Home Care ("MAHC") salary survey was not representative of the Provider's agency. Only one response was received from a proprietary agency, and the survey does not indicate any of the relevant characteristics of that agency. Similarly, the data contained in the National Association for Home Care ("NAHC") compensation survey appears to be statistically incomplete, and unreliable for evaluating owners' compensation under the Medicare regulations. The NACH survey is based on responses from various providers throughout the United States. In that survey, NACH received 25 responses from for-profit home health agencies. However, the survey does not indicate where the providers were located, the cost per visit of the agency, or whether the compensation levels reflected claimed or allowable salaries.

The Board also finds evidence indicating that the amount of compensation at issue in this case may be reasonable. The Provider engaged Dr. Randall Dunham, an expert on executive compensation in the health care industry, to perform an independent evaluation of the reasonableness of the Provider's owner's compensation. In the instant case, Dr. Dunham focused on the level of responsibilities as well as other criteria in determining reasonable compensation levels for the Provider's executives. According to Dr. Dunham's evaluation, reasonable compensation for the Provider's executives was substantially higher than the Michigan Survey results. The Board finds that the Dunham compensation analysis utilizes a better methodology, is more comprehensive, and represents the best evidence in the record.

The Board also finds that the Intermediary's adjustment is not substantively supported in accordance with 42 C.F.R. § 413.9(c)(2), Cost related to patient care-application. This regulation provides that necessary and proper costs are reimbursed however widely they may vary from one institution to another. However, Medicare program payments are subject to 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. The Board cannot conclude from the evidence presented that the amount of compensation at issue is substantially out of line with the compensation paid by like providers as described in 42 C.F.R.
§ 413.9(c)(2).

DECISION AND ORDER:

Issue 1 - Exception to Related Organization Principle:

The Intermediary's determination that the Provider did not meet the criteria for an exception to the Cost To Related Organizations regulation is correct. The Intermediary's adjustments to reduce the related organization's charges to cost are affirmed.

Issue 2 - Adjustment to Directly Allocate Salaries:

In that the Intermediary correctly determined that the Provider was subject to the Cost To Related Organizations principle, the adjustment to combine and reallocate the salaries of the related entities is proper.

Issue 3 - Disallowance of Owners Compensation Costs:

The Intermediary's adjustment disallowing a portion of the owners' compensation is improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (Dissenting)

Date of Decision: May 20, 1998

FOR THE BOARD:

Irvin C. Kues
Chairman

Dissenting Opinion of Henry C. Wessman

I write to dissent on Issues I and II; I concur with the decision on Issue III.

Regarding Issue I, I note that the test for an exception for a related organization is set forth in

42 C.F.R. § 413.7(d). There are four prongs to the test: 1) bona fide separate organizations; 2) a substantial part of the supplying organization's business is with non-related organizations; 3) services provided are not a basic element of patient care, and, 4) charges to the related organization are in line with, and comparable to, charges to others and the open market. My colleagues have determined that the Call-A-Nurse/Data-Med relationship is related; I agree. But, they also have concluded that the relationship only meets three (3) of the four (4) exemption prongs. I am persuaded that prong 2 (a substantial part of the supplying organization's business is with non-related organizations) is also met, and would thus qualify the relationship for a related party exemption available under 42 C.F.R. § 413.17. My decision is anchored upon stare decisis and pragmatic logic. In Tip of Illinois Health Services, Inc. v Blue Cross and Blue Shield of Iowa, (PRRB Dec. No. 93-D29, March 11, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,354; aff'd HCFA Admin. May 5, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,464) the Board, with Administrator affirmation, determined that 63% of day care services provided by a related service organization to "the general public" was sufficient to qualify that related organization relationship for meeting prong 2, and thus the exemption. The Board also found that 50% of the health club services provided to "the general public" by a related organization was equally sufficient; the Administrator reversed the Board on that issue. My pragmatic reading of this is that the word "substantial" in 42 C.F.R. § 413.17(d)(1)(ii) lies between 50 to 63%. I do not, for a moment, accept the arbitrary and unrealistic 10% limit set by the Intermediary. There has to be room for more than a scintilla of entrepreneurial spirit under the bureaucratic blanket of HCFA. In my judgment, based on the fact that 22 of 24 of Data-Med's clients were unrelated ("the general public"), and that they constituted 63 to 68% of Data-Med's volume, I conclude that the Call-A-Nurse/Data-Med related organization qualifies for the 42 C.F.R. § 413.17(d) exemption.

On Issue II, once again, the Intermediary attempts to stretch the bureaucratic blanket to disallow costs that are clearly appropriate. Specifically, reliance of the Intermediary on HCFA Pub.15-I, Section 2307.3 (Intermediary Position Paper, Exhibit I-8), HCFA Pub.15-I, Section 2313.2E (Provider Position Paper at 19), and Medicare Info Letter of May 30, 1989 (Provider Position Paper, Exhibit P-9) are irrelevant to this case, and misplaced. The "time studies" and "cost allocation" in the above-referenced Manual Sections refer specifically to documentation efforts within an organization between cost centers, not in the scenario presented here where you have related, but distinct, corporate entities, and certain employees who work for each on distinct tasks of work effort. In my opinion, because I believe that Call-A-Nurse/Data-Med qualify for the related organization exemption, I find the documentation presented by the Provider in Provider Exhibit 6 (Employee Itinerary); Exhibits 4 & 5 (Employee W-2 Forms, Call-A-Nurse and Data-Med), and Exhibit 13 (Individual Earnings Report/Hours) to be sufficient to identify the work effort of each of the three shared employees at each of the separate, but related, organizations. The Intermediary simply goes too far when it attempts to hold the Provider to a standard intended for in-house

documentation between cost centers, but which becomes arbitrary and capricious when stretched to cover separate, but related, organizations.

I concur with my colleagues and their finding/decision on Issue III; I would reverse the Intermediary's determination on Issues I and II.

_____

Henry C. Wessman, Esquire
Board Member