PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D68

PROVIDER -
Dyna Care Home Health, Inc.
Alsip, Illinois

DATE OF HEARING-
May 28-29, 1997

Provider No. 14-7407

Cost Reporting Period Ended - December 31, 1989 - December 31, 1994

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ Health Care Service Corporation, Inc.

CASE NOs. 92-1805, 93-0196, 94-0366, 95-0672, 96-0750, 97-0104

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ISSUES:

1. Was the Intermediary's adjustment offsetting key employees' compensation proper?

2. Was the Intermediary's adjustment to disallow Christmas gifts made to employees and third parties proper?

3. Was the Intermediary's adjustment to offset charitable contributions proper?

4. Was the Intermediary's adjustment to the Board of Directors' fee proper?

5. Was the Intermediary's adjustment to coinsurance amounts proper?

6. Was the Intermediary's adjustment to Medicare program visits proper?

7. Was the Intermediary' adjustment to medical supply charges proper?

8. Was the Intermediary's adjustment offsetting legal service fees proper?

9. Was the Intermediary' adjustment offsetting auto expense proper?

10. Was the Intermediary's adjustment applying sequestration factors proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Dyna Care Home Health Inc. is headquartered and licensed in Alsip, Illinois, a southwest suburb of Chicago. It serves 25 Illinois counties and also operates branch office locations in Michigan and Indiana. Dyna Care is a comprehensive, high-tech home care provider that specializes in procedures such as home blood transfusion therapy and home IV therapy. Visits increased from 11,891 in 1989 to 31,934 in 1994. Revenues increased from $907,000 in 1989 to over $5.5 million in 1994.

For the years ended December 31, 1989 through December 31, 1994, the Provider filed its Medicare cost report with the Intermediary which resulted in the issuance of a Notice of Program Reimbursement ("NPR") for each of the years. The NPRs effected various adjustments to costs claimed by the Provider including those adjustments referenced above.[1]

The Provider filed timely notices of appeal for each year with the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835-1841. The estimated Medicare effect is approximately $900,000. The Provider was represented by Ronald Scott Mangum, Esquire, of Mangum, Smietanka, &

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[1] Provider Position Paper, Exhibit 1.

Johnson, and the Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

Issue 1 - Was the Intermediary's adjustment offsetting key employees' compensation proper? (1989, 1990, 1991, 1992, 1993, 1994)

Compensation claimed for the current Administrator ranged between $88,000 and $161,000 for the years at issue. The former Administrator and current chief financial officer earned between
$96,000 and $136,000 during the same time frame.[2] The Intermediary disallowed a portion of the Provider's claimed owners' compensation each year, using the 1979 Dunham Survey ("Survey").

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly used the 1979 Survey to assess the reasonableness of the Provider's compensation.[3] The Survey contains a table which lists two "maximum amounts" of salary; Level 1 and Level 2 for the positions of Administrator and Assistant Administrator. The Intermediary testified that it was company policy to apply only Level 1 of the Survey and update that amount with HCFA inflation factors.[4] However, the Provider points out that it did not have an Assistant Administrator position, and that the Intermediary arbitrarily imposed the Intermediary's own job titles upon the Dyna Care executives.[5] When questioned about the application of the Survey, the Intermediary witness testified that he had never seen or used the auditor's instruction manual prepared by Dr. Randall B. Dunham, Ph. D., which described how the Survey should be used.[6]

The Provider also takes issue with the Intermediary's imposition of a revised inflation adjustment factor. In its position paper, the Intermediary corrected the Survey maximums and

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2 Id Exhibit 5.

3 Intermediary Position Paper 1-1. The Dunham Survey was developed by Dr. Randall Dunham, Ph. D., an expert witness in the area of health care compensation.

4 Provider's Post Hearing Brief at p. 6.

5 Id

6 Id at p. 7.

requested that the Board apply the revised (lower) compensation amounts.[7] The Provider points to Tri-Home Health Care and Services, Inc. v. Independence Blue Cross, PRRB Hearing Dec. No. 97-D37, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,152, wherein the Board required the Intermediary to provide proper notice to providers before changing the screen it used for executive compensation.

The Provider contends that 42 C.F.R. § 413.102 defines total reasonable compensation to include salary, personal benefits, assets and services given to the proprietor, and deferred compensation. The Provider also contends that the salary amounts in the Survey were incorrectly construed by the Intermediary to represent total compensation.[8] However, the Survey is only reflective of gross salary amounts and intended that employee benefits would be added. The Intermediary testified that the Survey ranges would be applied after including fringe benefits.[9] Thus, the Provider claims that the Intermediary arbitrarily chose to misuse the Survey relative to the area of fringe benefits.

The Provider points out that Dr. Dunham repudiated the Intermediary' application of the Survey In particular, Dr. Dunham cited the following areas:

1. Job titles/descriptions - While the Intermediary obtained job titles, it did not make an effort to obtain job descriptions. Dr. Dunham testified that: " [j]ob titles weren't as important as the responsibilities associated with the job... what really matters is what are the duties in that job".[10]

2. Level 1 v. Level 2 - Dr. Dunham stated that the Survey uncovered two different levels of responsibilities for administrative jobs in home health agencies, which he defines as Level 1 and Level 2.[11] Approximately 20% of administrative jobs in the Survey were found to be in the Level 2, higher category. With respect to the Provider, he notes that a small number of administrators manage a number of offices, without extensive use of consultants, while at the same time planning and achieving significant growth. These

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7 Intermediary Position Paper-1989, p. 6.
Id - 1990, p. 6.
Id - 1991, p. 14.
Id - 1992, p. 12.

8 Provider's Post Hearing Brief at p. 7.

9 Id at p. 14.

10 Tr. at p. 10.

11 Provider's Post Hearing brief at p. 13.

are characteristics of a Level 2 organization.[12] However, the Intermediary, as a matter of policy, refuses to recognize that any administrative job could be in the Level 2 category.[13]

3. Inflation adjustment- Dr. Dunham testified regarding the problems of trying to use an inflation adjustment, and described why and how a new compensation study should have been done.[14]

The Provider contends that if the Intermediary had utilized the Level 2 salary figures for the greater Chicago area and applied the relevant update amounts, an Administrator's salary of approximately $145,000 plus fringe benefits would be reasonable for the 1994 year.[15] Since fringe benefits are often in excess of 30% of salary amounts, total compensation for an Administrator would be over $188,000.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it attempted to properly determine the reasonable compensation levels for Provider's Administrator and Assistant Administrator in accordance with the regulations found at 42 C.F.R. § 413.102. The regulations permit a reasonable (amount ordinarily paid for comparable services by comparable institutions) allowance of compensation for services of owners as an allowable cost. To arrive at the reasonable amount, the Intermediary applied the Survey, updated by HCFA inflation factors.

The Intermediary contends that the use of the Survey compensation figures for a Level 1 Administrator and Assistant Administrator is in compliance with the requirements of HCFA Pub. 15-1 § 904, which establishes the criteria for determining reasonableness. The maximum of the Level 1 range was applied in recognition of the Provider's size, and to recognize the training and background of the employees whose compensation is being reviewed.[16]

The Intermediary points out that it compared the allowable compensation levels to other survey results. In particular, the Intermediary used the results of studies completed by the Health Care Services Corporation (HCSC), and the National Association for Home Care

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12 Id at p. 14.

13 Id at p. 16.

14 Tr. at p. 16-17.

15 Provider's Post Hearing Brief at p. 15.

16 Intermediary's Post Hearing Brief at p. 2.

(NAHC).[17] The Intermediary found that the results of both surveys were in line with the Dunham compensation levels.[18]

The Intermediary contends that if the Provider wishes the Board to disregard the Dunham Survey and the supporting surveys noted above, it has the burden to produce some evidence of the reasonableness of the claimed compensation levels. In the instant case, the Provider did not submit any alternative surveys or evidence that it sought the advice of any consultants or experts in the field of compensation. Instead, the Provider's main argument is that the Survey used by the Intermediary was not good enough. In the absence of better data, the Intermediary contends that the Survey, updated with HCFA inflation factors, provides the best available evidence for objectively determining reasonable compensation levels in this case.

Issue 2 - Was the Intermediary's adjustment to disallow Christmas gifts made to employees and third parties proper? (1989, 1990, 1991, 1992)

The Provider claimed expenses for gifts to its employees and to staff members at various physician offices. The Intermediary disallowed claimed costs as not related to patient care and not properly documented.

PROVIDER'S CONTENTIONS:

The Provider contends that small ($10 to $25) Christmas gifts given to Provider's employees and to staff of physicians with whom the Provider interacts are allowable costs. Specifically, the gifts to employees substitute for a much larger cash bonus, and serve to increase work efficiency, reduce turnover, and increase morale; all of which impact on patient care. The gifts to doctor's office staff are viewed as producing an enhancement to patient care by providing better coordination between the physicians and the staff of the Provider.

The Provider contends that these fringe benefits are reasonable, related to patient care, and proper in accordance with 42 C.F.R. § 413.9 which states in part: [n]ecessary and proper costs are costs that are appropriate in developing and maintaining the operation of patient care facilities and activities. Furthermore, the Provider points out that the Provider Reimbursement Manual, HCFA Pub. 15-1 § 2144.1 states that certain fringe benefits such as holiday parties and gifts are allowable so long as the costs are reasonable common and accepted occurrences in the provider area.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Christmas gifts were used to create and strengthen

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17 Exhibit I-3.

18 Intermediary's Position Paper at p. 10.

relations with physician offices with whom the Provider did business and received referrals. At the hearing, the Provider claimed that approximately 75% of the gifts were given to employees. However, the Provider indicated this was only an estimate, and there were no records to establish how many of the gifts went to employees as opposed to physician offices.[19]

The Intermediary contends that in the absence of documentation for the claimed gifts to employees, the expenditures were treated as costs related to the solicitation of business from patients or referring physicians. These types of expenses are viewed as not related to patient care because they are not necessary for the rendering of services to Medicare beneficiaries. Accordingly, the Intermediary based its adjustment on 42 C.F.R. § 413.9 which limits allowable costs to those related to patient care.

Issue 3 - Was the Intermediary's adjustment to offset charitable contributions proper? (1990, 1991, 1992, 1993)

The Intermediary disallowed the costs of charitable contributions made by the Provider as not related to patient care. The amounts in question are 1990 - $10,100; 1991 - $1,280; 1992 - $400; & 1993 - $5,120.

PROVIDER'S CONTENTIONS:

The Provider contends that based on Medicare Program Transmittal No. 375 ("Transmittal 375"), Intermediaries are instructed not to disallow previously allowed expenses, such as charitable contributions, prior to March 1, 1994 if they have been previously allowed. Transmittal 375 states in part: "[b]ecause these types of costs have not been explicitly addressed in this manual, intermediaries will not disallow such costs incurred prior to March 1, 1994." Id.

The Provider contends that Transmittal 375 notes that such costs have traditionally been allowed or denied by intermediaries on an ad hoc basis, which has created uncertainty for providers in attempting to comply with regulations. Since the Intermediary allowed charitable contributions incurred by the Provider in 1987, the Provider is of the opinion that the Intermediary must, in accordance with Transmittal 375, allow those costs in years prior to March 1, 1994.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the charitable contributions are not allowable as per 42 C.F.R. § 413.9,which requires that costs must be reasonable and necessary to the maintenance of operations for patient care. HCFA Pub. 15-1 § 2102.3 specifically excludes the cost of

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[19] Tr. May 28, 1997 at pp. 77-78.

charitable contributions as not necessary and proper in the development and maintenance of operations of patient care facilities.

The Intermediary contends that the Provider's argument, that Transmittal 375 would allow the charitable contributions, is invalid. Immediately preceding the sentence quoted by the Provider, Transmittal 375 clearly states: "[t]he purpose of this revision is to amplify existing instructions. That is, the absence of prior explicit instructions related to these costs does not mean that the costs were allowable". Id. Thus, the Intermediary asserts that Transmittal 375 merely adds clarifying language to HCFA Pub. 15-1 § 2102.3, and in no way changes the intent of the instruction.

The Intermediary also contends that the Provider's argument that such contributions were permitted in the past is without merit. No documentation was submitted to support a previous (1987) contribution. A review of the Provider's prior year Income Statement did not reflect a charitable contribution expense. The fact that any non-allowable cost may have been overlooked or mistakenly permitted in a prior year does not change the fact that the cost is non-allowable under the Medicare program, and must be adjusted when found.

Issue 4 - Was the Intermediary's adjustment to the Board of Directors' fee proper? (1991,1992)

The Provider maintains a five member Board of Directors, including three shareholders and two non-shareholder physicians. Each Director received $5,000 in 1991 and 1992 for their services. However, the Intermediary only allowed a total of $500 and $300 for those years, as reflective of a reasonable amount. The Provider is contesting only those Board of Director fees paid to the two non-employee Board members.

PROVIDER'S CONTENTIONS:

The Provider contends that the directors fees were reasonable, based on the duties performed. Each of the non-salaried board members spent about 30 to 40 hours in each of the two years in question. This consisted of at least one three day retreat, 10 to 15 short meetings, and 6 to 8 key employee interviews, as well as an intensive annual review of policies, procedures, and agency operations.[20] In addition, the physician Board members attended survey exit conferences and reviewed medical policies and procedures, functions which would cost the agency $7,000 to
$10,000 per year, if an independent consultant was utilized.

The Provider contends that the reasonableness of the Board fees should be compared to the amounts paid to other directors in comparable agencies. However, the Intermediary did not conduct a survey, nor did it demonstrate that the costs incurred were out of line with

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[20] Id at p. 50-54.

comparable providers. In that the Intermediary appears to have made an ad hoc, arbitrary determination, the Provider contends that the entire disallowance should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it reviewed the claimed fees pursuant to 42 C.F.R. § 413.9 (reasonableness) to determine if the fees were reasonable in view of the services performed by the Board members. To accomplish this, the Intermediary requested minutes of the Board meetings. Although the Provider's witness testified there were 10 to 15 Board meetings a year, some were only phone calls between the Administrator and an individual Board member.[21] The Intermediary only received one set of minutes for a 1991 meeting, and one set for a 1992 meeting. An examination revealed that the minutes do not indicate the duration of the meeting, who participated in discussion or debate, or who presented the agenda topics listed.

The Intermediary points out that the Board itself set the annual reimbursement fee at $5,000, absent any outside advice as to reasonableness, or without determining what other providers might be paying for similar services. In view of the lack of evidence presented, the Intermediary contends that its allowance of an annual $100 nominal fee for each non-employee Board member is quite reasonable.

Issue 5 - Was the Intermediary's adjustment to coinsurance proper? (1991, 1992, 1993 & 1994)

The Intermediary used PS&R data to effect the final settlement of the Medicare cost reports. Coinsurance on Part B claims was calculated to be 20% of billed charges and served to reduce the cost settlement each year.

PROVIDER'S CONTENTIONS:

The Provider contends that under Medicare Part B reimbursement rules it is entitled to be reimbursed the Medicare reasonable charge, less the coinsurance amount. They believe the Intermediary is improperly adjusting the coinsurance on the Medicare cost report.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that coinsurance on Part B claims is 20% of billed charges, and that the Provider is to collect the coinsurance either from the patient or the patient's private insurance carrier. In settling the Medicare Part A cost report, the Intermediary treats the coinsurance revenue as a reduction in the cost settlement.

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[21] Id at p. 81.

The Intermediary contends that its methodology is required by the HCFA cost reporting forms/instructions (Form 1728-86) at line 18. The purpose of the reduction is to ensure that the Provider is not reimbursed twice, first by the patient and again by Medicare. Since the Provider acknowledged that it received the 20% coinsurance amount from its patients, they are not entitled to the same payment twice.[22]

Issue 6 - Was the Intermediary's adjustment to Medicare program visits proper? (1989, 1990, 1991, 1992, 1993, 1994)

The Intermediary is required under HCFA reporting requirements to use the PS&R for Medicare cost report settlement purposes. It used the PS&R amounts to determine total visits, Medicare visits, and total paid claims for the Provider's cost report settlements.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's use of the PS&R data results in an underpayment to the Provider in that visits are paid late, and may be paid at a rate which is lower than the Provider's actual cost at the time the visit occurred. This is due to the fact that the Intermediary only recognizes home health visits actually paid by Medicare during the year, regardless of the date of service.

The Provider contends that the Intermediary should use an accrual accounting method based on billed charges and substitute that data for the PS&R when effecting settlement of the Provider's Medicare cost reports.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it uses the PS&R data because it represents the claims actually adjudicated by the Part B carrier for each provider during a particular year. It is considered the most accurate record of billed charges since it excludes claims that have not been approved by the carrier.

The Intermediary contends that the Provider's assertion that the PS&R data is not accurate is without merit. To obtain as complete a report as possible, the PS&R is run for a period to include fifteen months after the close of the fiscal year under appeal. Any claims not included in the PS&R will be included in the next fiscal year. If the Intermediary finds that claims from previous years have a substantial impact on reimbursement, the prior year's cost report can be reopened.

The Intermediary also points out that the Intermediary witness testified that the Provider's alleged problems with the use of the PS&R had no real reimbursement impact on the

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[22] Id at p. 101.

Provider.[23] The Provider asserted that certain claims filed in 1992 were not included in the final PS&R. However, the Provider cannot or has not followed those claims through subsequent reporting periods. Adjustments to coinsurance amounts actually resulted in a favorable adjustment to the Provider. With respect to the alleged 1993 missing claims, the reimbursement impact was determined to be immaterial, and could therefore be accounted for in the subsequent cost reporting period.

Issue 7 - Was the Intermediary's adjustment to medical supply charges proper? (1989, 1990, 1993 1994)

The Intermediary adjusted amended bills submitted for additional Part A medical supplies. Amounts at issue are $14,410 in 1989, $2,781 in 1990, $26,025 in 1993, and $5,793 in 1994.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary (without explanation) would not allow the Provider to submit adjustment bills to reflect Part A medical supplies that may have been omitted on
the original bills. The Provider indicates that it now has a new Intermediary that recognizes these same types of adjustment bills and points to the inconsistency with respect to HCFA claims processing policy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary witness testified that he was not familiar with this particular issue but believed it to be a billing issue rather than a reimbursement issue.[24] The Intermediary opted not to address this particular issue in its position paper or post hearing brief.

Issue 8 - Was the Intermediary adjustment offsetting legal service fees proper? (1992, 1993, 1994)

The Intermediary disallowed accruals of $ 10,000 each for the years 1992, 1993 and 1994, relating to the future cost of legal fees relative to this appeal. The accrued amounts were not liquidated within the time frame prescribed by HCFA Pub. 15-1 § 2305.

PROVIDER'S CONTENTIONS:

The Provider contends that it made its best estimate of the cost of legal fees related to the appeal, and accrued that amount in three of the years under appeal (1992-1993). Through no

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23 Id at p. 127.

24 Id at p. 134.

fault of the Provider, the appeal took over five years to reach the hearing stage, and consequently the legal fees were not paid until 1996 and 1997. While the Provider can claim the costs in the year paid, this runs counter to the intent of Medicare that accrual accounting be used, and as applied, will financially harm the Provider. The Provider points out that it exceeded the cost limits in 1996 and may be over the limits in 1997. Accordingly, not allowing the expense in the year accrued will result in the Provider not being reimbursed for these otherwise allowable costs, due to the cost limits applicable to the years in which the expenses were paid.

The Provider contends that HCFA Pub. 15-1 § 2305.1 allows the Intermediary to grant an exception (for good cause) to the one year time limit for liquidation of accruals. In this situation the Provider argues that the delay in bringing these appeals to hearing, and therefore the period in which the associated legal costs are paid, is not under the control of the Provider. Therefore, the Provider contends that it is entitled to a waiver of the provision that accrued expenses must be paid within 12 months after the end of the cost reporting year.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider improperly accrued estimated legal fees relating to pending PRRB cases. At the time of the accrual, there were no legal services rendered and there was no obligation to the Provider to pay at that time. The accrual was merely an estimate of a future obligation.

The Intermediary points out that HCFA Pub. 15-1 § 2305 requires that a short term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. Section 2305.1 provides an exception to the one year rule when the Provider presents written documentation that: (1) there was insufficient cash flow to pay the bill, or (2) there was an accounting error in the receipt and processing of bills. In the instant case, the Provider did not liquidate the accrued liability within the one year time frame, nor did it submit the required written justification for an extension of the time period for liquidation.

Issue 9 - Was the Intermediary's adjustment offsetting auto expense proper? (1992, 1993, 1994)

The Provider claimed operating expenses and depreciation on three Provider owned automobiles. The Intermediary disallowed all expenses due to insufficient documentation.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred in disallowing all automobile expenses solely because the Provider's logs do not detail the split between business and personal miles. During the hearing the Provider's witness testified that sufficient mileage logs existed to

verify the use of the vehicles.[25] Theses contemporaneous records indicated time, destination, purpose and mileage.[26] Further, the witness testified that each of the employees have their own automobiles for personal use, and that they reimbursed the Provider for any personal use of the company vehicles, which mainly consisted of commuting mileage.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. § 413.24 requires adequate cost data to support the claimed auto expenses. In particular, the regulation requires that the cost data must be accurate, in sufficient detail to accomplish the purpose for which it is intended, and capable of being audited. In the instant case, the Intermediary found the mileage logs were not maintained in sufficient detail to support the claimed expenses, nor were they auditable.

The Intermediary argues that to be sufficient and auditable the logs should include the following information: beginning and ending odometer readings for each trip; identification of trips and mileage that are personal in nature; specific destinations for each trip; and the purpose of each trip. The Intermediary contends that information of this detailed nature is necessary in order to determine if the auto expense is related to patient care. Both the Administrator and Assistant Administrator were officers of a second corporation which is not a Medicare provider. Thus, they could have incurred travel expenses for either corporation on any given day. With only general total mileage and insufficient descriptions of the trip purpose, it is not possible to make a proper determination as to the allowability of the claimed cost. Therefore, the Intermediary deemed that the mileage logs did not meet the requirements of 42 C.F.R. § 413.24.

The Intermediary contends that the Provider made inconsistent claims as to how the personal use of the automobiles was handled. The canceled checks from the Provider's officers purporting to be reimbursement for personal use of company vehicles were not accompanied by any documentation to show how the amounts were developed.

Issue 10 - Was the Intermediary's adjustment applying sequestration factors proper? (1989, 1990)

The Intermediary reduced reimbursement according to the sequestration provisions of the Gramm-Rudman Act.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment report does not provide sufficient

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[25] Id at p. 69-70.

[26] Id at p. 92-93.

specificity to determine if the sequestration factor was properly applied. Accordingly, the Provider contends the adjustment should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary stated at the hearing that it would stand on the record that it has supplied, that it applied the factors.[27] No additional evidence or testimony wss provided to rebut the Provider's contention on this issue.

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.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.102	-	Compensation of Owners

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

§ 900	-	Principle
§ 904	-	Criteria for Determining Reasonable Compensation
§ 2102.3	-	Costs Not Related to Patient Care (Amended by Trans. No. 375)
§ 2144.1	-	Fringe Benefits- Definition
§ 2305	-	Liquidation of Liabilities
§ 2305.1	-	Exception to 1-Year Time Limit

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[27] Id at p. 11.

4. Cases:

At Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Case No. 98-D44, April 23, 1998.

Tri-Home Health Care and Services, Inc. v. Independence Blue Cross, PRRB Case No. 97-D37, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,152.

Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Wisconsin, PRRB Case No. 97-D28, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,062, declined rev. HCFA Administrator, March 7, 1997.

5. Other:

Medicare Program Transmittal No. 375

1979 Dunham Survey

HCFA Cost Reporting Forms/Instructions (Form 1728-86)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue 1- Disallowance of Owners' Compensation Costs

The Board notes that the Intermediary has an obligation under the regulations and manual to develop information that can be used to evaluate the reasonableness of owners' compensation. In the instant case, the Intermediary has relied upon the 1979 Dunham Survey, updated for inflation. The Board has previously found the surveys conducted by Dr. Dunham to be a reasonable method to develop comparable compensation levels. See Upper Peninsula Home Nursing v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Wisconsin, PRRB Case No. 97-D28, January 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,062, declined rev. HCFA Administrator, March 7, 1997 and, most recently, At Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Case No. 98-D44, April 23, 1998. (Not as yet published in the Medicare and Medicaid Guide (CCH).

The Board notes that HCFA Pub. 15-1 § 900 et seq. specifies guidelines for determining the reasonableness of owners' compensation. The Intermediary is required to obtain information

on compensation paid by comparable institutions in the same geographical area. In assessing comparability, the Intermediary is to consider the size and type of institution, as well as the duties and responsibilities of the owners. Then, a range of compensation for positions at comparable institutions is to be developed and used to determine reasonableness.

The Board finds that in this particular case the Intermediary applied the maximum Level 1 amount from the Survey in recognition of the Provider's size, and the training and background of its owners. By contrast, the evidence shows that the owners set their own compensation levels without surveying the market place or seeking the advice of consultants or other experts in the area of executive compensation. Nor did the Provider submit any type of independent study or survey to support its contentions.

The Board also notes that there was no evidence in the record, such as job descriptions, to support a higher compensation level. In addition, the record did not contain any evidence or proof that the inflation factors used by the Intermediary were incorrect.

The Intermediary is responsible for determining the reasonableness of owner's compensation. The Board finds that the 1979 Dunham Survey, as used by the Intermediary, utilized a valid methodology and represents the best evidence in the record.

Issue 2 - Disallowance of Christmas Gifts

The Board notes that Christmas gifts to employees would generally be recognized as an allowable cost. However, there was no documentation, other than oral testimony, that a portion of the expense may have been for employees. In the absence of records and written documentation, the Board finds that the evidence, when viewed as a whole, indicates that the Christmas gifts were used to strengthen business relationships with various physician offices. As such, these expenses would not be allowable as per 42 C.F.R. § 413.9, which limits allowable costs to those which are related to patient care.

Issue 3 - Disallowance of Charitable Contributions

The Board finds that the charitable contributions are not an allowable expense under the Medicare program, in that they are not related to patient care as required by 42 C.F.R. § 413.9. The Board also finds that Medicare Program Transmittal 375 serves to clarify the language of HCFA
Pub. 15-1 § 2102.3, and should not be viewed as an escape clause permitting the allowance of otherwise non allowable costs.

Issue 4 - Board of Directors' Fees

The Board notes that the evidence indicated that minutes of the alleged multiple Director's meetings (other than one meeting per year) were not presented to the Intermediary.

Additional testimony revealed that many of the designated Director's meetings were actually telephone calls between the Administrator and an individual member of the Provider's Board of Directors. The Board finds that the Provider has not provided sufficient auditable documentation to support an allowance beyond the amount recognized by the Intermediary.

Issue 5 - Coinsurance Adjustment

The Board finds that, in settling the Medicare cost report, the Intermediary reduced the cost settlement by the coinsurance revenue on Part B claims. The evidence presented indicates that the Provider collected the 20% coinsurance amount from its patients. Accordingly, the Board finds that the Intermediary's adjustment correctly served to prevent a duplicate payment to the Provider, first by the patient and then by the Medicare program.

Issue 6 - Adjustment to Medicare Program Visits

The Board finds that the Intermediary is required under HCFA reporting requirements to use the Provider Statistical and Reimbursement Report (PS&R) for Medicare cost report settlement purposes. The Provider argues that the Intermediary should use total billed charges to settle the cost report rather than total paid claims. However, the Board notes that the Provider's suggestion would not be appropriate, since it would include claims that had not been adjudicated and approved by the carrier.

The Board finds that there was no persuasive evidence in the record to indicate that the PS&R was inaccurate, or that the use of the PS&R had a material adverse impact on the Provider's overall reimbursement. The Board finds that the PS&R is the proper source of data to effect settlement of the Medicare cost report.

Issue 7 - Medical Supply Charges

The Board notes that the Provider has presented testimony which indicates that its former Intermediary would not allow the Provider to submit adjustment bills for previously omitted medical supplies, while its current Intermediary will accept claims of this nature. The Board also notes that the former Intermediary did not address this issue in its initial position paper or post hearing brief. The Board finds that the Provider's current Intermediary should revisit this issue and determine the validity of any medical supply costs which were incurred but unbilled.

Issue 8 - Legal Fees

The Board finds that HCFA Pub. 15-1 § 2305 requires that a short term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. Section 2305.1 provides an exception to the rule in cases where there is insufficient cash flow or due to an accounting error in the receipt and processing of bills. The Board

notes that the Provider did not liquidate the accruals within one year of the end of the respective cost reporting periods, and did not submit written justification for an extension of the time period for liquidation. The Board finds that, in view of the above, the legal fees were not allowable expenses in the years in which they were accrued.

Issue 9 - Automobile Expenses

The Board notes that the Provider maintained only an estimate of the total miles driven and very general descriptions as to the purpose of the trips. The Provider's Administrator and Assistant Administrator were also officers of a second corporation which is not a Medicare provider. The Board also notes that both individuals performed services for each entity.

The Intermediary pointed out that the individuals could have incurred travel expenses for either corporation. Some portions of the trips may have resulted in personal usage or in unrelated business purposes. However, without auditable records it was not possible to determine the allowability of the claimed cost.

The Board finds that the Intermediary was correct in requiring adequate cost data to support the claimed auto expenses. The Medicare regulations at 42 C.F.R. § 413.24 require that the cost data must be accurate, in sufficient detail to accomplish the purpose for which it is intended, and capable of being audited.

The Board finds no evidence in the record that the Provider's automobile records met the requirements of 42 C.F.R. § 413.24. In summary, the Provider has not submitted sufficient documentation to support its claimed automobile expenses.

Issue 10 - Sequestration

The Board finds that the Intermediary reduced the Provider's reimbursement in 1989 and 1990 by applying the sequestration amounts required under the Gramm-Rudman Act. The Provider states that the only issue at hand is that it was not able to determine what factors the Intermediary used in calculating the sequestration amount. The record indicates that neither party produced any evidence or testimony relative to this issue. Absent information to the contrary, the Board finds the Intermediary calculation to be proper.

DECISION AND ORDER:

Issue 1 - Disallowance of Owners' Compensation Costs

The Intermediary's adjustment reducing owners' compensation was reasonable and proper. The Intermediary's adjustment is affirmed.

Issue 2 - Disallowance of Christmas Gifts

The Intermediary's adjustment of the Provider's Christmas gift cost was proper. The Intermediary's adjustment is affirmed.

Issue 3 - Disallowance of Charitable Contributions

The Intermediary's adjustment of the Provider's charitable contributions cost was proper. The Intermediary's adjustment is affirmed.

Issue 4 - Board of Directors' Fees

The Intermediary's adjustment of the Provider's Board of Directors' cost was proper. The Intermediary's adjustment is affirmed.

Issue 5 - Coinsurance Adjustment

The Intermediary's adjustment of the Provider's cost report settlement for coinsurance amounts is proper. The Intermediary's adjustment is affirmed.

Issue 6 - Adjustment to Medicare Program Visits

The Board finds that the PS&R is the proper source of data to settle the Medicare cost report. The Intermediary's use of the PS&R for cost report settlement purposes is affirmed.

Issue 7 - Medical Supply Charges

The Board finds that the Provider may have incurred costs for additional medical supplies but adjustment bills were denied by the prior Intermediary. The current Intermediary is directed to revisit this issue and determine the propriety of the claimed medical supplies.

Issue 8 - Legal Fees

The Intermediary's adjustment of the Provider's legal fee cost was proper. The Intermediary's adjustment is affirmed.

Issue 9 - Automobile Expenses

The Intermediary's adjustment of the Provider's automobile expenses was proper. The Intermediary's adjustment is affirmed.

Issue 10 - Sequestration

The Intermediary's calculation of sequestration amounts under the Gramm Rudman Act is affirmed.

Board Members Participating:

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

Date of Decision: June 25, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman