PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D29

PROVIDER -
Golden Years CORF
Boca Raton, FL

Provider No. 10-4549

vs.

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

DATE OF HEARING-
March 7, 2001

Cost Reporting Periods Ended -
October 31, 1993

CASE NO. 97-0159

INDEX

ISSUES:

Was the Intermediary's adjustments to the Provider's therapy costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Medi-Gold Associates, Inc. d/b/a Golden Years CORF ("Provider"), was a Comprehensive Outpatient Rehabilitation Facility (CORF) located in Boca Raton, Florida. A related organization, Golden Years Day Care, Inc. operated an adult day care program in the same building that housed the Provider's operations. The Blue Cross and Blue Shield of Florida (Intermediary) adjusted the cost of the Provider's Occupational Therapy (OT) and Speech Therapy (ST) services for the fiscal year ended October 31, 1993.

The Provider entered into contracts to provide therapy services at the offices of independent providers of therapy services to patients who needed the services and who could not receive services that were otherwise covered by Medicare. The agreement covered two different services that were needed to allow the Provider to provide services to Medicare beneficiaries; (1) the lease of equipment and space; and the (2) acquisition of therapy services.

The Intermediary Using the HCFA Outpatient Facilities Uniform Desk Review Program reviewed the Provider's cost of Occupational and Speech Therapy and found it to be unreasonable and consequently denied a portion of the cost for those therapists. The Provider disagreed with the Intermediary's adjustments and filed an appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.§§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount in contention is approximately $ 45,903.

The Provider was represented by Thomas William Baker, Esq of Troutman Sanders, LLP. The Intermediary was represented by Bernard M Talbert, Esq., of the Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that audit adjustment No. 6 disallowing speech language and occupational therapy costs should be reversed. Medicare regulations require the reimbursement of the reasonable costs of obtaining therapy services under arrangements. The costs related to the acquisition of speech language and occupational therapy are reimbursable in accordance with the prudent buyer principle. Since the Provider's costs were within the prudent buyer limits, they should be reimbursed in full.

The Provider points out that because there were no salary equivalency amounts published for speech pathology and occupational therapy services for the time period in question, the Provider should have been reimbursed in accordance with the prudent buyer principle. 42 C.F.R 413.9(b)

and HCFA Pub. 15-1 §2103. On October 28, 1993, HCFA published a Program Memorandum[1] in which HCFA established a prudent buyer limit of $95 per hour for the acquisition of speech language and occupational therapy services. The Provider also contends that the Intermediary's calculation of the number of visits was incorrect.

The Provider argues that in adjusting speech language and occupational therapy costs, the Intermediary reviewed only the Provider's off-site arrangement contracts, which had two components, lease costs and therapy costs, and allowed only the amount allocated to therapy costs. This is the exact opposite of the Intermediary's position in the following cost report year in which the Intermediary treated all of the cost, including the lease cost, as the cost of acquiring therapy services under arrangements.

The Provider contends that a portion of the costs of the off-site arrangement should be allocated to the lease of space, and all of these costs should be allowed as reasonable and necessary. Any adjustment of the cost of acquiring speech language and occupational therapy services in any other than the off-site arrangement should not be based on the off-site arrangements.

The original statutes and regulations when read together required that (1) CORFs be reimbursed based upon reasonable costs and (2) all services (with the exception of one home visit) be provided at one site. In 1982, final rules regarding CORF services were promulgated by HCFA with substantial comments.[2] These regulations provided that all CORF services must be furnished at a single site with the exception of one home visit to evaluate the potential impact of the home environment on rehabilitation goals. In their comments to the regulations, the Department of Health and Human Services expressly stated that it was the Department's interpretation that Congress did not intend to allow a CORF to deliver off-site therapy services.

However, in 1987, Congress specifically recognized the need for the delivery of a CORFs therapy services off of the CORF's premises, and corrected the Department misinterpretation of the original CORF statute, and made an explicit, affirmative change in the way CORFs could provide therapy services. Section 4078 of the Public Law No. 100-203 (Omnibus Budget Reconciliation Act of 1987) amended Section 1861 (cc)(1) of the Social Security Act (42 U.S.C. §1395x(cc)(1) by adding the following:

> In the case of physical therapy, and speech pathology services, there shall be no requirement that the item or service be furnished

---

[1] Exhibit P-1.

[2] See Exhibit P-2.

> at any single, fixed location if the item or service is furnished pursuant to such plan [plan of care] and payments are not otherwise made for the item or service under this title [Medicare].

Therefore, the Provider argues that the law was changed to make it clear that CORFs can provide off-site therapy services so long as such services are delivered as an integrated part of a rehabilitation plan and payments are not otherwise made under Medicare. The regulations, were also amended in 1991 to show clearly that a CORF can provide therapy services off-site.[3]

The Provider points out that a CORF should be reimbursed for all reasonable costs related to providing services to Medicare beneficiaries. CORFs are reimbursed on a reasonable cost basis. Social Security Act 1833(a)(2)(B) (42 U.S.C. § 1395(a); 42 C.F.R. §§ 413.1, and 413.9 provide that "all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and costs." 42 C.F.R. §413.9(a).

The Provider contends that the lease payments related to the provision of therapy services at an off-site location are reasonable. The Provider disagrees with the Intermediary's contention that the salary equivalency doctrine applies only to the acquisition of therapy services under arrangements and not to the lease of space and equipment related to a CORF's delivery of therapy services at a location away from the CORF's primary site.

The Provider argues that the costs related to the lease of space and equipment are reimbursable costs, regardless of whether the CORF supplied therapy services through its employees or through independent contractors. If the CORF acquires therapy services through independent contractors, then the salary equivalency doctrine or the prudent buyer principle, as applicable to the type of therapy acquired, places limits only on the cost related to the acquisition of therapy services, not to other unrelated costs.

If the CORF provided therapy services through its employees, then the salary equivalency doctrine becomes irrelevant. The position that the costs related to legitimate space and equipment leases should be reduced when a CORF provides therapy services through an independent contractor rather than an employee is arbitrary, capricious, and unsubstantiated by any law.

The Provider contends that the application of 42 C.F.R.§ 413.106 and chapter 14 of HCFA Pub. 15-1 to its lease payments is unjust and inequitable because, this authority does not apply to a CORF's lease of space and equipment related to its services. Since the lease payments were

---

[3] See Exhibit P-3.

necessary and proper costs and in compliance with 42 C.F.R. §413.9(c)(2), they should be reimbursed.

The Provider argues that it relied to its detriment on the Intermediary's representation that lease payments related to providing therapy services off-site would be reimbursable costs, and, therefore, the Intermediary should be estopped from adjusting these costs. Before drafting its contract for the acquisition of off-site therapy services, the Provider called the Intermediary to request its advice on reimbursement for costs related to the delivery of off-site therapy services. Specifically the Provider asked the Intermediary whether lease payments related to the provision of therapy services are reimbursable. The Intermediary assured the Provider that lease payments related to the provision of therapy services off-site are reimbursable as reasonable costs. In reliance on the Intermediary's answer to the Provider's questions, the Provider drafted a standard contract that it used to acquire therapy services at off-site locations.[4]

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the Provider was incorrect when it stated that on October 28, 1993, HCFA published a program Memorandum in which HCFA established a prudent limit of $95 per hour for the acquisition of OT and ST services. HCFA stated that this was only an indicator to determine if further audit review was necessary. It did not preclude the Intermediary from using a lower amount as a test of reasonableness. It was not meant to be used as HCFA's prudent buyer limit.

The Intermediary also points out that under the HCFA Outpatient Facilities Uniform Desk Review Program, the intermediary is required to review the reasonable costs of other therapy services. The auditor had only the Provider's Working Trial Balance (WTB), the PS&R Report and the Contracted Therapy Service Agreements as the sources of information. The contract defined the services, the rate structure, and the measure of time constituting a unit. However, the Provider did not furnish copies of patient service logs, or other documentation of patient services to enable the auditor to identify services to individual patients, includings dates of service, number of units of service, number of patient contacts, or charged billed and billing codes.

The Intermediary points out that according to the contract between the Provider and the therapists the Provider agreed to pay the therapists $ 8 per unit, each unit consisting of fifteen minutes. The Intermediary used $32/hour as the basis to test the reasonableness of the therapists' salary expense. Since $32 was equal to one visit, than $32 times the number of visits should equal the total therapy expenses of the Provider.

The Intermediary contends that HCFA requires intermediaries to verify the reasonableness of expenses incurred by a Provider under 42 C.F.R. §413.24 which states:

---

[4]Exhibit P-1

(a) Principle. Providers receiving payment on the basis of reasonable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTIONS:

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

§1395(x)(cc)(Social Security Act §1861(cc)(1)	-	Agreeements with Providers of Service
§1395(a)(Social Security Act §1833(a)(2)(B)	-	Agreements with Providers of Services

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9et seq.	-	Cost Related to Patient Care
§ 413.1	-	Introduction
§ 413.106	-	Reimbursable Cost of Physical and Other Therapy Services Furnished Under Arrangements
§ 413.24	-	Adequate Cost Data And Cost Finding

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

§ 2103	-	Prudent Buyer

4. Other:

Omnibus Budget Reconciliation Act Public Law 100-203.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, the facts, parties' contentions, and evidence presented on the record finds that the Provider is entitled to the Occupational and Speech Therapy costs for the fiscal year ended October 31, 1993.

The Board finds that there was a lack of documentation in both the Provider's and Intermediary's record. The Board used the best evidence available which was the PS&R. The Board determined through analysis that the Provider's costs were reasonable and in compliance with the prudent buyer concept. The Board notes that the HCFA guide for OT and ST costs was $95 per visit, compared to the Provider's lesser cost per visit. The Board also notes that there was no officially published limit for OT and ST.

DECISION AND ORDER:

The Provider's cost for Occupational and Speech Therapies was reasonable and within the guidelines set by HCFA. The Intermediary's adjustment is reversed.

Date of Decision: May 14, 2001

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman