PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D30

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, 1994

CASE NO. 97-0160

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ISSUES:

Were 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. Blue Cross and Blue Shield of Florida (Intermediary) adjusted the cost of the Provider's Occupational Therapy (OT), Speech Therapy (ST) services and Physical Therapy (PT) for the fiscal year ended October 31, 1994.

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 denied the Provider's cost for the lease of equipment and space. 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 $ 102,000.00.

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 points out that because there were no salary equivalency amounts published for speech pathology, occupational therapy and physical 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.

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[1] Exhibit P-1.

The Provider argues that in adjusting 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.

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 and physical therapy services in any other than the off-site arrangement should not be based on the off-site arrangements.

The Provider contends that therapy services can be provided by a CORF away from the CORF's premises, if the services are delivered as an integrated part of a rehabilitation plan and payments are not otherwise made under Medicare.

The Provider points out that in 1980 Congress enacted Section 933 of Public Law 96-400, which amended several sections of the Social Security Act to define "a Comprehensive Outpatient Rehabilitation Facility" (CORF) as a distinct type of Medicare provider and included CORF services as a new benefit under Medicare Part B. Social Security Act §1861(CC)(1), codified at 42 U.S. C. §1395(x)(cc). The statutory amendments require that CORFs will be paid based upon reimbursement of their costs related to patient care.

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, corrected the Department's 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

[2]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 [including CORFs] must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable costs include 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

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[3]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]

The Provider contends that the Intermediary incorrectly disallowed 1,125 hours of physical therapy services that were actually performed by the Provider. The Provider argues that the hours as reported on its Medicare cost report are correct and that the Intermediary's Work Paper B-6 cannot be relied upon because it has no factual foundation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that it adjusted the rent expense of $173,443 to exclude the rent paid to the 10 off-site physical therapy facilities, which were operated by the contracted outside physical therapists. The difference of $102,371 was reclassified from the Administrative & General cost center to the Physical therapy cost center, since the payments were made to the therapists for the use of their office space. The Intermediary argues that amount should be combined with the total compensation paid to the outside physical therapists prior to the comparison with the applicable physical therapy cost on the Medicare cost report, Form HCFA - 2088-92, Worksheet A-8-3.

The Intermediary contends that the rental of an off-site treatment facility for CORF services is not reasonable. The original intent of Congress was to enable Medicare beneficiaries to receive coordinated comprehensive rehabilitation services at one location, rather than having to travel to different locations to receive a variety of rehabilitation services. This was pointed out by HCFA's response to comments from the public in the Federal Register dated December 15, 1982, volume 47 §56,282. Some of the commenters objected to this restriction in delivering services, stating that homebound and rural beneficiaries would be deprived of CORF services, since they may have to travel a long distance to reach the nearest CORF. However, HCFA cited the following reference in the December 15, 1982 Federal Register:

[4]Exhibit P-1

> The House Committee on the Budget report on the 1980 Omnibus Reconciliation Act (H.R. Rep. No. 96-1167, 96th Congress, 2nd Session, P375) recounted the various disjointed settings in which the Medicare program covers rehabilitation services, thus requiring beneficiaries in need of multiple services to seek them at various locations. The report emphasized that the provisions of section 933 of that Act were intended to remedy this situation by recognizing a CORF as a new type of provider under Medicare, capable of furnishing a broad array of rehabilitation services in a coordinated fashion. The Provision of routine services at off-site locations would dispel the very reason for a CORF's existence. Therefore, the Intermediary argues that all CORF services (except for one home visit) were supposed to be furnished on-site, on the premises of the Provider's physical location, effective for services furnished on or after 12-15-82.

The Intermediary points out that Congress added the exceptions to the Medicare law in order that PT, OT and ST services could be furnished away from the premises of the CORF. However, the Medicare Conditions of Participation for CORF's at 42 C.F.R. § 485.51 still state that a CORF or facility means a nonresidential facility that provides specific services at a single fixed location. Section 484.54 further states that the facility must be currently licenced or approved by the state. Thus, it appears that a CORF cannot extend its business area by acquiring work space at other locations. Also it would be unreasonable to assume that a CORF could establish satellite offices, which, as Congress stated "would dispel the very reason for a CORF's existence."

The Intermediary points out that 42 C.F.R. § 485.58(e) (Medicare Conditions of Participation for CORFs) allow PT, OT and ST services to be furnished away from the premises of the CORF. However, there is no mention that any off-site facility can be acquired or rented in order to perform these services. Therefore, these services appear to be very similar to the visits that are furnished by a Medicare certified Home Health Agency, which cannot include any facility costs from the location where the service is actually rendered. Since the Provider has already been reimbursed for the overhead expenses related to the CORF's single fixed location, it does not seem reasonable or prudent for the Medicare program to pay the CORF for expenses incurred at another treatment site. This would duplicate the overhead expenses such as depreciation, maintenance/operation of plant and housekeeping which are allocated to the Medicare and other rehab patients through the Medicare cost report.

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 buyer 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, and dates of service, number of units of service, number of patient contacts, charges 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 per 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:

> (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.

The Intermediary determined that the PT contracted hours were 3936. Therefore, the Intermediary adjusted the PT hours on the form HCFA 2088-92 Worksheet A-8-3, column 2, line 9 from the reported number of 5061 to 3936.

The Intermediary contends that since all off-site services were performed at the suppliers' premises, no travel expenses would be allowed for Medicare reimbursement. Therefore, it removed the PT unduplicated census days of 4046 from W/S A-8-3 column 1, line 3 and removed the PT standard travel expense of $2.50 per day from W/S A-8-3 column 1, line 7 via the adjustment 8.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTIONS:

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

§1395(x)(cc) (Social Security Act §1861(CC) -	Agreements with Providers of Services
§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
§ 413.1	-	Introduction
§ 413.9 et seq.	-	Cost Related To Patient Care
§ 413.106	-	Reimbursable Cost of Physical and Other Therapy Services Furnished Under Arrangements
§ 485.51	-	Conditions Of Participation
§ 484.54	-	Conditions Of Participation Compliance With State and Local Law
§ 485.58 et seq.	-	Conditions of Participation Comprehensive Rehabilitation Program
§ 413.24	-	Adequate Cost Data And Cost Finding

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

Chapter 14	-	Reasonable Cost Of Therapy And Other Services Furnished By Outside Suppliers
§ 2103	-	Prudent Buyer

4. Other:

Omnibus Budget Reconciliation Act Public Law 100-203.

Public Law 96-400, § 933

Form HCFA 2088-92 Worksheet A-8-3.

Federal Register Dec. 15, 1982 volume 47 §56,282.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions, and evidence in the record, finds that there are actually three sub-issues in this case.

The first issue relates to adjustment #5, which involves the intermediary's reclassification of rental expense, moving the cost from the A&G cost center to the physical therapy cost center. The Board finds that Medicare regulations allow a CORF to make off-premises visits for all therapy visits. The Medicare regulations are also silent as to whether or not rent or lease costs are allowable for CORF. The Board finds that the cost of the outside suppliers of therapy which include their off-site rent expense was a reasonable cost and in compliance with the prudent buyer concept. The Board finds that there is no adjustment necessary to the Physical Therapy expense on A-3, as the A-8-3 schedule creates a limitation to these cost when warranted.

The second issue relates to adjustment #6 which involves the reasonable cost of the Occupational, Speech, and the Physical Therapists. The Board finds that the Provider's costs for the therapists were lower than the $95 cost limit set by HCFA. The Board finds through analysis this amount to be reasonable and within the guidelines of the prudent buyer concept. The Board finds there was a lack of documentation in both the Providers and Intermediary's records. The Board used the best evidence available which was the PS&R. The Board also notes that there were no officially published limits for OT and ST.

The third issue contains three parts. The third issue relates to adjustment #8, the Board must decide the number of physical therapy hours reported by the Provider, the travel expense, and the unduplicated census days. The Board finds that the number of hours submitted by the Provider was incorrect. The number of hours used by the Intermediary is the correct number of hours since there is no evidence in the record submitted by the Provider to counter the Intermediary's claim. Therefore, the Board concludes that the number of PT hours which the Intermediary adjusted was the most accurate number of hours.

As to the travel issue, the Board finds that there was a lack of convincing arguments and documentation to substantiate the Provider's contentions. The Intermediary did give the Provider the standard allowance of $16.50 but disallowed the additional $2.50 for travel expenses requested by the Provider. Therefore, the Intermediary's adjustment is affirmed.

As to the unduplicated census days, the Board finds that there was a lack of documentation to substantiate the Provider's contention. Therefore, the Board accepts the Intermediary's adjustment.

DECISION AND ORDER

Sub-Issue No. 1

The Intermediary's reclassification for the rent expense was not proper. The Intermediary's adjustment is reversed.

Sub-Issue No. 2

The Provider's cost of Physical, Occupational, and Speech Therapy was reasonable within the guidelines set by HCFA. The Intermediary's adjustment is reversed.

Sub-Issue No. 3

The Intermediary's adjustment to the number of physical therapy hours was correct

The Intermediary's adjustment to the provider's travel expense was correct.

The Intermediary's adjustment to the census days was correct.

The Intermediay's adjustments to A-8-3 are upheld.

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