PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D38

PROVIDER –
Select Home Health
Denver, Colorado

Provider No. 06-7239

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/Cahaba Government Benefits Administrator

DATE OF HEARING
February 14, 2002

Cost Reporting Period Ended
November 30, 1995

CASE NO. 98-1171

INDEX

ISSUE:

Was the Intermediary's determination of legal fees proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Select Home Health of Denver, the ("Provider") is a Medicare certified home health agency, servicing the metropolitan area of Denver, Colorado. In February 1995, another Denver based home health agency filed suit against three of the Provider's employees who had been formerly employed by the competing agency. Two of these employees were registered nurses-one was employed by the Provider as a field nurse and the other was employed as the Provider's Director of Nursing. Both nurses had signed agreements with their former employer, which prohibited them from soliciting the former employer's patients and key referring physicians.

The Provider was aware of the existence of these agreements prior to hiring the nurses. The Provider and the former Director of nursing testified at the PRRB hearing that it was their understanding that the agreements had prohibited only active solicitation of the former employer's patients and about a half-dozen key referring physicians and that, even with regard to these patients and referring physicians, the nurses could have professional contact with, including providing services to, the same, provided that such contact was initiated by the patient or referring physician. Subject to this understanding, the nurses believed that they had honored their agreements with their former employer.

The February 1995 suit against the Provider's employees alleged, that the nurses had violated the anti-solicitation provisions of the agreements and sought an injunction to prevent the nurses from having contact with certain patients and referring physicians. During discovery, the former employer produced a list of nearly two hundred Denver-based physicians that it claimed were its key referral sources- some of who, it was later revealed, had been dead for several years.

The Provider and the employees regarded the suit as frivolous. However, the Provider was concerned that, absent a coordinated defense, his employees' former employer agency might be successful in getting the injunction granted. If that were to occur, the nurses would be prohibited from performing many of their patient care-related duties for the Provider. Accordingly, the Provider agreed to undertake the defense of the suit filed against its employees in order to prevent or, minimize any disruption to the delivery of patient care services. The suit was eventually settled for a nominal monetary amount and the agreement that the nurses would be enjoined, for a ten-month period, from soliciting a list of about one dozen referring

physicians. The settlement did not enjoin the nurses from providing patient care services to any of their former employer's patients.

The Provider on its November 30, 1995 cost report claimed costs associated with attorney fees. Cahaba Government Benefit Administrators ("Intermediary") disallowed the attorney fees. The Provider was not satisfied with its Intermediary's determination and filed a timely appeal with the Provider Reimbursement Review Board ("Board"). The Provider's appeal met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Danielle Lombardo Trostorff, Esq. and Sherry S. Landry, Esq. of Locke, Liddell & Sapp LLP. The Intermediary was represented by Bernard M. Talbert,.Esq. of the Blue Cross and Blue Shield Association. The Medicare reimbursement at issue in this appeal is approximately $39,434.

PROVIDER'S CONTENTIONS:

The Provider contends that the legal fees incurred as a result of its participation in the defense of the suit brought against its employees were reasonable costs related to patient care that are allowable under the provisions of Section 1861 (v)(1)(A) of the Social Security Act, 42 C.F.R 413.9 and Section 2183 of the Provider Reimbursement Manual. Specifically, the Provider contends that the legal fees were necessary and proper costs that were appropriate and helpful in maintaining the operation of patient care activities. Accordingly, the Provider avers that its motive in undertaking the defense of the suit was directly related to patient care.

The Provider maintains that pursuant to § 1861 (v)(1)(A) of the Social Security Act, Medicare-certified providers are entitled to recover all reasonable costs actually incurred of any services covered under the Program that are related to the efficient delivery of needed health services. "Reasonable costs" are defined in 42 C.F.R. § 413.9 as "all necessary and proper costs incurred in furnishing services ...." "Necessary and proper costs" are defined as those costs that "are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." Further, Section 2183 of CMS Pub. 15-1 provides that "[1]egal fees and related costs incurred by a provider are allowable if related to the provider's furnishing of patient care." Provider contends that the legal fees at issue meet all the aforestated criteria.

The Provider argues that the legal fees were not only appropriate and helpful, but were, in fact, integral to the maintenance of its patient care activities. As noted above, one of the employees named in the suit was employed by the Provider as a field nurse who was responsible for providing direct patient care services to many of the Provider's patients. Several of these patients had followed, of their own volition, the field nurse to the Provider after she left the services of her former employer. The Provider asserts that if the injunction sought by the former

employer of the field nurse had issued, there is no question that the field nurse would have been prohibited from providing direct patient care services to several Provider's patients, notwithstanding the existence of carefully developed and nurtured nurse-patient relationships or the freedom of choice rights guaranteed to these patients by the Medicare Program. The only alternative to the Provider's undertaking the defense of the suit would have been to reassign these patients to another nurse-caregiver, which would not have been in the best interests of the patients.

The Provider points out that it offered testimony at the Hearing that in the home health industry, it is considered to be in the best interest of the patient to have the same field nurse visit a patient's home on a regular basis. Many home health patients, as well as their families, initially experience anxiety with having a stranger enter their homes, but if the same nurse-caregiver visits day in and day out, there is the opportunity to build a relationship of trust with the patients and their families and to relieve such anxiety. The Provider also notes that the Medicare Program mandates that providers not interfere with a patient's freedom of choice in selecting their caregivers.

The Provider points out that the suit also sought to enjoin the then-Director of Nursing from having contact with nearly two hundred physicians in the Denver metropolitan area that her former employer claimed to be its key referral sources. The duties of the Director of Nursing included responsibility for performing intake of physician orders, serving as a liaison between the field nurses and physicians and providing direct patient care services on a backup basis. Pursuant to the Colorado Nursing Practice Act, only a nurse, or other such licensed professional, could perform intake of physicians orders and that she was the only licensed professional in the home office that could perform such services. All of the other qualified and licensed professionals were assigned to the field. Also, it was necessary for the Director of Nursing to serve as the liaison between the field nurses and the physicians, which required the Director of Nursing to have the ability to communicate with every physician that referred patients to the Provider.

The Provider contends that although the Provider itself would not have been enjoined from providing services to patients or interacting with referring physicians, the Provider's ability to maintain normal patient activities would have been severely impaired if its key employees were so enjoined. The Provider argues that it is the employees and not the entity that actually perform the patient care services.

The Provider contends that the Board's decision in Lutheran General Hospital v. Mutual of Omaha, PRRB Dec. No. 82-D82, April 23, 1982, Medicare and Medicade Guide ("CCH") § 31,948 the provider claimed the legal fees as a necessary and proper expense and the Board agreed, reasoning as follows:

The facts in this case clearly demonstrate that the provider reached a conclusion that continuance in the community mental health program would be detrimental to the quality of its private mental health facility. There is no evidence in the record that this conclusion was incorrect or unreasonable. Thus, to reverse this situation, a cost was incurred to seek relief from the provider's obligations pursuant to the terms of the community mental health center grant. Accordingly, these costs are deemed to be necessary and proper costs, inasmuch as they enhance the quality of patient care, Hence, the legal.., fees are allowable Medicare costs.

Id.

The Provider argues that, like Lutheran Hospital, it incurred legal fees to seek relief from a suit that would have had a detrimental effect on its ability to maintain normal patient care activities. The Provider asserts that it undertook the defense of the suit for the sole purpose of preventing, or, at the very least, minimizing, disruptions in the delivery of patient care services to its patients. Accordingly, the Provider concludes that the legal fees should be deemed necessary and proper costs, inasmuch as they were incurred to enhance the quality of patient care.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that its adjustment was made in accordance with CMS Pub. 15-1 § 2102.3 which states:

> Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary include costs which usually are not common or accepted occurrences in the field of the provider's activity.

The legal fees were paid on behalf of the Provider's employees who were sued by their former employer. These employees were named as defendants in the lawsuit, which alleged that they had committed the following acts:

1. Breach of contract
2. Misappropriation of Trade secrets
3. Deceptive trade practices/consumer protection
4. Breach of duty of employment

The complaint alleged that two of the employees left their employment with their former agency to start a new agency, the Provider who was newly certified on November 2, 1994 and thereby transferred the former employers trade secrets, patient

lists and referring physician lists to the Provider. The former employer also alleged that these employees had lured away another employee.

According to the former employer's complaint, these employees' actions were in violation of a severance agreement, a confidentiality agreement, and duty of employment. The former employer sought to obtain monetary compensation from the three employees and to prevent them from further use of trade secrets, including client and physician lists.

The Intermediary contends that because the Provider was not named in the suit, the cost of its defense is not related to patient care. The former employer did not seek to prevent the Provider from servicing its clients, but only sought to prevent its former employees from further violating their agreements. If the former employer had been completely successful in obtaining the relief it sought, the Provider would still have been legally able to provide service to all of its patients.

The Intermediary contends that the costs incurred for the protection of trade secrets is not related to patient care and is non-allowable. These costs only serve to prevent other providers from infringing on the Provider's market share and to keep the competition down. They do not have an impact on the care of the Provider's patients.

The Intermediary points out that this issue is similar to Gulf Coast Home Health Group Appeal - Legal Fees v. Aetna Life Insurance Co. PRRB Dec. No. 90-D64, Sept. 26, 1990, Medicare and Medicaid Guide ("CCH") § 38,873 CMS Administrator declined review, Nov 5, 1990 affd, Gulf Coast Home Health Services, (D.C.C. 1992) Medicare and Medicaid Guide ¶ 40,133. In this case, the provider sought the reimbursement of legal fees incurred to protest a Certificate of Need (CON) applicant. The provider in this case asserted that it was necessary for them to participate in the CON proceedings in order to protect themselves against a potential revenue loss, a personnel shortage or an increase in personnel costs. The Board found that the legal fees were not related to patient care and were non-allowable. The following is a portion of the Board's decision:

While the costs in question may have been considered business expenses, "even necessary business expenses must also be necessary to patient care in order to be reimbursed under Medicate." Sun Towers, Inc. v. Hechier US Court of Appeals, Fifth Circuit, No. 82-1841, Feb. 21, 1984.

The Intermediary contends that the Gulf Coast case is similar to the Provider's in that both providers incurred legal fees to protect their client and referral base. As the Board noted in Gulf Coast, fighting the lawsuit might have made good business sense, however, this does not mean that the cost is related to patient care.

The Intermediary argues that the suit lodged by the employee's former employer was an attempt to enforce non-competition agreements against former employees. Although the Provider itself was not named in the suit, the Provider paid for the defense of the suit to protect its client and referral base. The costs incurred by providers in competing for patients and physician referrals are not related to patient care and are not allowable.

The Intermediary contends that in Florida Medical Center, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No 93-D-19, Feb. 19, 1993 Medicare and Medicaid Guide ("CCH") § 41,573 the issue before the Board was the intermediary's disallowance of legal fees incurred by the provider. There, the legal fees were incurred in the Provider's defense of a law suit brought against it by one of its joint venturers, concerning ownership of the provider and how profits should be distributed among the owners. The provider argued that the legal fees were necessary expenditures that were related to patient care in that the suit posed a direct threat to the provider's assets and its ability to continue providing care.

However, the Board rejected the provider's argument, finding that the legal fees were directly related only to the resolution of an equity interest disagreement between the non-related parties to a joint venture.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Costs Related to Patient Care

3. Program Instructions-Provider Reimbursement Manual (CMS Pub.15-1):

§ 2102.3	-	Costs Not Related to Patient Care
§2183	-	Legal Fees andOther Related Costs

4. Cases

Lutheran Genral Hospital (Omaha, Neb.) v. Mutual of Omaha, PRRB Dec. No. 82-D82, April 23, 1982, Medicare and Medicaid Guide ("CCH") § 31,948.

Gulf Coast Home Health Group Appeal –Legal Fees v. Aetna Life Insurance Co., PRRB Dec. No. 90-D64, Sept. 26, 1990, Medicare and Medicaid Guide ("CCH") § 38,873. CMS Administrator decline to review, Nov. 5, 1990 aff'd, Gulf Coast Home Health Services, (D.C.C. 1992) Medicare and Medicaid Guide ("CCH") ¶ 40,133.

Sun Towers, Inc. v. Heckler, U.S. Court of Appeals, Fifth Circuit, No. 82-1841, Feb. 21, 1984.

Florida Medical Center, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 93-D19, February 19, 1993, Medicare and Medicaid Guide ("CCH") §41,573.

FINDINGS OF FACT,CONCLUSIONS OF LAW AND DISCUSSION:

The Majority of the Board, after consideration of the facts and parties' contentions, and testimony at the hearing find and conclude that the Provider's legal expenses were not directly related to patients care, and are therefore not reimbursable under the Medicare program.

The majority of the board find that the Provider:

1. Hired the employees after knowing that there was a limitation on them
2. There was evidence that only three patients were documented to have left with the employees
3. The final resolution indicated that only thirteen doctors were involved
4. There were significantly high amounts of legal fees
5. The employees could have been replaced as they left the employ of the Provider at later date and that patient care was not affected.

The majority of the Board finds that the suit lodged by the former employer was an attempt to enforece noncompetition agreements against former employees. Even though the Provider was not named in the suit, the Provider paid for the defense of the suit to protect its client and referral base. The costs incurred by providers in competing for patients and physicians referrals are not related to patient care and are not allowable costs. Competitive forces were the primary motivation for both parties to the lawsuit in an attempt to protect market share rather than patient care or quality of care.

The Majority of the Board concludes that the legal expense incurred by the Provider were not directly related to patient care. While the majority of the Board finds that the Provider had the right to protect its employees, it does not warrant Medicare reimbursement.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's cost report to remove legal fees was correct. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire (Dissenting Opinion)

Date of Decision: September 18, 2002

FOR THE BOARD

Irvin W. Kues
Chairman