PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2003-D11

PROVIDER –
SNI Home Care, Inc.
Langhorne, PA

Provider No. 39-7279

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
Record Hearing
October 22, 2002

Cost Reporting Period Ended
October 31, 1997

CASE NO. 00-2451

INDEX

ISSUE:

Were the Intermediary's adjustments to physical therapy costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

SNI Home Care, Inc. ("Provider") is a Medicare-certified home health agency located in Langhorne, Pennsylvania. During the fiscal year ending October 31, 1997, the Provider rendered approximately 5000 physical therapy ("PT") visits. Visits were performed by full and part time employees. In addition, the Provider also entered into contracts with both individual physical therapists as independent contractors and with healthcare companies who supplied therapists to provide PT services.

The Provider filed its Medicare cost report with Wellmark, now known as Cahaba Government Benefit Administrators ("Intermediary") in 1998. The Intermediary conducted a field audit of the fiscal year 1997 cost report and issued a Notice of Program Reimbursement ("NPR") dated September 30, 1999.[1] That NPR reduced the reimbursement for services of the Provider's physical therapy employees who were paid on a per visit basis by applying the Medicare Program Equivalency Guidelines for Physical Therapy ("Guidelines"). On March 24, 2000, the Provider filed an appeal with the Provider Reimbursement Review Board ("Board")[2] pursuant to 42 C.F.R. §§ 405.1835-.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $85,000.

The Provider was represented by Elizabeth L. Hambrick, Esquire, of Arent Fox, Kintner Plotkin & Kahn, PLLC. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the salary equivalency guidelines used by the Intermediary were not intended to be applied to employee physical therapists. The law at 42 U.S.C. § 1395x(v)(5)(A) provides that where physical therapy services are furnished under arrangement with a provider of services or other organization, the amount allowable for Medicare reasonable cost reimbursement purposes shall not exceed the reasonable salary that would have been paid for the same services (together with any additional costs that would have been incurred by the provider or other organization) under an employment relationship with the provider or other organization. The allowable cost (the salary equivalency) was

[1] Provider Exhibit P-59.
[2] Provider Exhibit P-60.

to include other reasonable expenses incurred by the outside supplier in providing PT service, such as travel time, administrative costs, etc.

The Provider explains that implementing regulations at 42 C.F.R. § 413.106 limit payments for services rendered by specialists (such as physical therapists) who work for Medicare providers "under arrangements" to the salary equivalency guidelines.

In pertinent part, 42 C.F.R. § 413.106(a) states that:

> [t]he reasonable cost of the services of physical, occupational, speech and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in Section 1861(w) of the Act) with a provider of services, a clinic, a rehabilitation agency, or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such an arrangement.

The Provider also notes that CMS Pub. 15-1 § 1400 states:

> [t]he reasonable cost of the services of physical, occupational, speech, and other therapists, or services of other health-related specialists (except physicians) performed by outside suppliers for a provider of services, a clinic, a rehabilitation agency, or a public health agency is limited to: (1) amounts equivalent to the salary and other costs that would have been incurred by the "provider if the services had been performed in an employment relationship, plus (2) an allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements.

Moreover, at CMS Pub. 15-1 § 1403, the manual explicitly states: "[t]he guidelines apply only to the costs of services performed by outside suppliers, not the salaries of providers' employees."

The Provider contends that the courts have held in In Home Health Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 300,005 (D. Minn. June 16,

1998), aff'd 188 F.3d 1043 (8th Cir. 1999), 1999-2 Medicare & Medicaid Guide (CCH) ¶ 300,326 (" In Home Health"), that physical therapists paid on a "fee-per-visit basis" are bona fide employees if they are in an employment relationship with a provider. In the instant case, parallel facts define the Provider's relationship with its per visit employee-physical therapists who were paid on the same basis as In Home Health's per-visit therapists. As in In Home Health, the Provider's per visit employees accepted compensation for physical therapy services based upon the number of visits they performed. Consistent with its duty as an employer, the Provider withheld and paid all applicable payroll taxes. In addition, physical therapist employees were entitled to participate in all benefits such as health insurance, the pension plan, and the benefits plan, on the same basis as other employees. The Provider also provided malpractice insurance, a mileage reimbursement, and a telephone allowance.

The Eighth Circuit held that In Home Health physical therapists compensated on a per-visit basis who were in an employment relationship, as evidenced by the employer's actions of paying employment taxes and allowing participation in employee-only benefits, were not outside suppliers. Applying the court's reasoning to the instant case, the Provider contends that its per visit physical therapists have all of the same characteristics as in the In Home Health case. As such, these therapists should be deemed to be employees, not outside suppliers subject to the Physical Therapy Guidelines.

The Provider also points to two recent Board decisions that support the Provider's assertion that 42 C.F. R. § 413.106 and CMS Pub. 15-1 § 1403 do not apply to per visit employee physical therapists. See VNA of Maryland, LLC v. Blue Cross and Blue Shield Association/Cahaba Government Benefits Administrator, PRRB Dec. No. 2001-D39, August 8, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,729, rev'd. CMS Administrator, October 9, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,787, and Tulsa Home Health Services v. Mutual of Omaha Insurance Co., PRRB Dec. No. 2001-D44, August 30, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,734, rev'd CMS Administrator, November 1, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,781.

The Provider also contends that the relevant regulation at 42 C.F.R. § 413.9 provides that :

> [a]ll 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 costs inludes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

In the instant case, the Intermediary has not shown that the Provider's physical therapy costs were not in accord with the Medicare prudent buyer principles. Nor did the Intermediary demonstrate that the Provider's costs were substantially out of line with similar providers. Instead, the Intermediary proposed a methodolgy which purported to demonstrate that the Provider's actual cost of $ 68.23 per visit exceeded a per visit amount of $ 52.25 found in an informational, non-governmental 1997-1998 Homecare Salary & Benefits Report.[3]

The Provider asserts that the Intermediary's methodology is faulty for several reasons. First, the survey was not statistically valid as there was no random sampling. Second, the report rate was derived from looking at costs across the entire state rather than in the Provider's own geographical location. Finally, the Intermediary's use of a 50th percentile amount may not represent the prevailing salary rate in the Provider's clinical service and recruiting area. In view of these factors, the Provider engaged an experienced consulting company that compiled data from three home health agencies in the Provider's area. The 75th percentile of costs per visit for comparable agencies was $ 68.12,[4] while the Provider's cost per visit was $ 68.23. The Provider also points out that its Medicare physical therapy cost limit for the year at issue was $ 125.28. Following the normal step-down of administrative and general costs, the Provider's calculated average cost per visit for physical therapy services was only $ 117.12.[5] Thus, the Provider contends it is entitled to be paid the reasonable costs it incurred to provide physical therapy services.

The Provider also explains that neither the current nor prior Intermediary ever advised the Provider that the cost of employee-physical therapists paid on a per visit basis would be treated as services provided by an outside supplier. Accordingly, the Provider never applied for an exception to the guidelines.The Intermediary finally notified the Provider of the potential need to apply for an exception in the Intermediary's Preliminary Position Paper dated July 6, 2001. This was long after the the regulatory time frame for filing, which is 90 days after the close of the cost reporting period. Since receiving that notification, the Provider prepared an exception request and contends that it should be considered timely in view of the factors cited.

The Provider also argues that CMS violated a Medicare statute and the Administrative Procedures Act by adopting a new rule without providing notice

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[3] Provider Exhibit P-66.
[4] Provider Exhibit P-73.
[5] Provider Exhibit P-73.

to the public and allowing for comment. It asserts that 42 U.S.C. § 1395hh[6] provides that no rule, requirement, or other statement of policy that establishes or changes a substantive legal standard governing the scope of payment for services shall take effect unless it is promulgated by the Secretary of Health and Human Services ("Secretary") after advance notice and opportunity for comment. The Administrative Procedure Act contains similar requirements. 5 U.S.C. § 553.[7]

The Provider also contends that the Intermediary applied the Guidelines to its PT costs retroactively, which is unlawful. The Provider explains that the Intermediary first applied the guidelines in 1995, and cites Health Insurance Association of America, Inc. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994), reversing the district court's summary judgment in favor of the Secretary and holding that the Secretary could not recover payments previously made on the basis of interpretive rules which did not exist when the transactions at issue were conducted. See also Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988) (affirming district court's summary judgement that the Secretary could not retroactively apply a salary index for hospital employees).

The Provider contends that the Intermediary's retroactive application of the guidelines also violates 42 U.S.C. § 1395gg(c), which provides in part:

> [t]here shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

Finally, the Provider contends that it is unlawful for the Intermediary to apply the guidelines to its PT costs because they have not been updated as required by duly promulgated regulations. Specifically, the Provider asserts that CMS is obligated to set the guidelines according to 42 C.F.R. § 413.106(b)(1),[8] which states:

> [t]he hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full-time in an employment relationship.

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[6] Provider Exhibit P-3.
[7] Provider Exhibit P-4.
[8] Provider Exhibit P-6.

The Provider explains that CMS has not analyzed therapist salary ranges since 1982, and CMS's only revision of the guidelines since that time has been to apply a fixed monthly percentage increase of 0.6 percent per month. That rate has fallen far behind the salaries which the market actually requires providers to pay employee physical therapists.

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the audit adjustment which applied the physical therapy guidelines to the employee physical therapists was made in accordance with the provisions of Medicare regulations. 42 C.F.R. § 413.9 - Cost Related to Patient Care; 42 C.F.R. § 413.106 - Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements; and CMS Pub. 15-1, Chapter 14, and Section 2103 - Prudent Buyer.

Specifically, 42 C.F.R. § 413.106(c)(5) states:

> [u]ntil a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service.

This regulation is implemented by CMS Pub. 15-1 §1403 which reads in part, that:

> [u]ntil specific guidelines are issued for the evaluation of the reasonable costs of other services furnished by outside suppliers, such costs will continue to be evaluated under the Medicare programs requirement that only reasonable costs be reimbursed.

The Medicare regulation at 42 C.F.R. § 413.9(c)(2) also states that:

> [t]he costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

The Intermediary asserts that the amount paid by the Provider for physical therapy services was not prudent to the extent of $65,184 for the cost reporting year under appeal. With regard to total hours worked and total cost of outside

suppliers, the Provider was unable to support the hours submitted on Worksheet A-8-3. Therefore, when adjusting total physical therapy hours, the Intermediary assumed that one visit equaled one hour.

According to CMS Pub. 15-1 § 1409.2:

> [w]here time records of home health visits are unavailable or found to be inaccurate, the reasonable cost evaluation is based on visits rather than actual hours of services rendered. Each home health agency visit is considered the equivalent of 1 hour of service.

Emphasis added.

Employee Physical Therapist

The Intermediary does not dispute that the Provider's physical therapists were employees. However, according to CMS Pub. 15-1 § 1403, "in situations where compensation, at least in part, is based on a fee-for-service or on a percentage of income (or commission), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter." (Emphasis added.) As the Provider's physical therapists were paid on a per-visit basis, it is the Intermediary's position that they are subject to the physical therapy guidelines.

According to CMS Pub. 15-1 §1403, there are several situations in which compensation of a salaried physical therapist would be subject to the limitation in Chapter 14. This section reads in part:

> the costs of the services of a salaried employee who was formerly an outside supplier of therapy or other services, or any new salaried employment relationships will be closely scrutinized to determine if an employment situation is being used to circumvent the guidelines. Any costs in excess of an amount based on the going rate for salaried employee therapists must be fully justified.

The Intermediary asserts that CMS, in its wisdom, realized that certain salaried employment relationships would effectively circumvent the guidelines and provided for these in Section 1403.

Further supporting the Intermediary's position is the CMS Administrator's reversal of the Board's decision in High Country Home Health Care v. IASD Health Services Corp., PRRB Dec. No. 97-D35, March 19, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,130, rev'd, HCFA Admin., May 20, 1997,

Medicare & Medicaid Guide (CCH) ¶ 45,543. In that decision, the HCFA Administrator ruled that the Intermediary properly applied the Salary Equivalency Guidelines per CMS Pub. 15-1, Chapter 14 to the "per-visit" compensated physical therapists.

Also, the HCFA Administrator reversed the Board's decision in In Home Health vs. Blue Cross and Blue Shield Association/Blue Cross & Blue Shield of Iowa, PRRB Dec. No. 96-D16, February 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,065, rev'd., HCFA Admin., October 28, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,942. In that decision, the HCFA Administrator reversed the Board's decision and ruled that the Intermediary properly applied the Salary Equivalency Guidelines per CMS Pub. 15-1, Chapter 14 to the "per-visit" compensated physical therapists.

Although the above HCFA Administrator's decisions were overturned by the U.S. District Court of Appeals in Minnesota and Wyoming, the District Court decision does not apply to this case, as the Provider is located in Pennsylvania.

Application of Guidelines to Employees

The Provider argues that the Intermediary erroneously adopted and applied the guidelines to employees and unlawfully applied 63 Fed. Reg. 5106 (January 30, 1998) retroactively.

It is the Intermediary's position that Medicare policy requiring the application of the physical therapy guidelines to fee-for-service physical therapists does not involve application of a substantive rule, nor is the policy new. The rulemaking requirements of the Administrative Procedure Act ("APA") are not applicable to interpretive rules, general statements of policy, or rules of agency organization, procedure or practice.

The Intermediary points to 63 Fed. Reg. 5106, (January 30, 1998), which states on page 26 that:

> [t]he entire compensation will be subject to the guidelines in cases where the nature of the arrangements are most like an "under arrangement" situation, although the provider may technically treat the therapists as employees. The guidelines will be applied in this situation so that an employment relationship is not being used to circumvent the guidelines. Since June 1977, our longstanding policy on this issue has been contained at section 1403 of the Provider Reimbursement Manual. We are now establishing this provision in regulations that further the statutory purpose of cost control as reflected in the legislative history of the guidelines.

(Emphasis added.)

Therefore, contrary to the Provider's arguments, it is not a new application of policy. Nor was it a substantive rule which required notice and comment prior to implementation; rather, the instructions interpret and clarify existing legislation and regulatory instruction regarding the Guidelines' applicability to physical therapist compensation paid under arrangements.

Prudent Buyer Principle

It is the Intermediary's position that because the Provider's physical therapy costs exceeded the physical therapy guidelines, the costs are not reasonable and that they are, in fact, substantially out of line.

For purposes of preparing for this appeal, the Intermediary has compared the Provider's cost to the 1997-1998 Homecare Salary & Benefits Report ("Report"). As explained in the Report, the data is based on a salary survey that was conducted in August, 1997 by Hospital and Healthcare Compensation Service by means of a mailed questionnaire sent to home health care agencies. The per-visit rates shown below are taken from the results categorized as "high." This was determined by arranging the salary data in order of magnitude and then calculating the 25th, 50th and 75th percentiles. The middle 50 percent of the data is used, thereby eliminating salaries which are very high or low.

Physical Therapists Survey Area	Per Visit Rate	Number of Incumbents	Page Number
Pennsylvania	$ 52.25	252	IV- 21
Region 2 - For-profit	$ 51.08	31	VI - 4
Region 2 - Total	$ 50.84	1,004	VI - 4
[Rate from 'high' category]			

According to the1997-1998 Homecare Salary & Benefits Report, the high rate for physical therapists paid on a per-visit basis in Pennsylvania was $ 52.25 per visit. The Provider's actual cost per visit of $ 68.23 is 30% higher than the high rate from the survey. This supports the Intermediary's position that the Provider's rates per visit are substantially out of line.

As is evident from comparing the Survey results to the cost limit, home health agencies located in the Provider's area are able to employ physical therapists at a rate that is at or below the cost limit. CMS Pub. 15-1 § 2103 states that the prudent and cost conscious buyer refuses to pay more than the going price for an item or service and seeks to economize by minimizing cost. The amount paid by

the Provider for physical therapy services was not prudent to the extent of $65,184.

Guidelines Not Adequately Updated

The Provider argues that the guidelines have not been adequately updated. According to 42 C.F.R. § 413.106(f), providers may request exceptions to the limits if the provider demonstrates that certain conditions exist. Exceptions may be granted because of unique circumstances or special labor market conditions. However, the provider must demonstrate that the guidelines are inappropriate for them because of these circumstances or conditions in the area. The Intermediary does not have any record of the Provider requesting such an exception to the physical therapy guidelines; therefore, the limits as defined by the regulations should be applied in this case.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law – United States Code ("U.S.C.")

   5 U.S.C.:

§ 553	-	Rule Making

   42 U.S.C.

§ 1395gg et seq.	-	Overpayment on Behalf of Individuals
§ 1395hh	-	Regulations
§ 1395x(v)(5)(A)	-	Reasonable Cost

2. Regulations – 42 C.F.R.

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Cost Related to Patient Care
§ 413.9(c)(2)	-	Application
§ 413.106 et seq.	-	Reasonable Cost of Physical and Other Therapy Services Furnished Under

		Arrangement
§ 413.106(a)	-	Principle
§ 413.106(b)(1)	-	Prevailing Salary
§ 413.106(c)(5)	-	Application
§ 413.106(f)	-	Exceptions

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

§ 1400	-	Principle
§ 1403	-	Guideline Application
§ 1409.2	-	Full-Time or Regular Part-Time Services
§ 2103	-	Prudent Buyer

4. Federal Register:

63 Fed. Reg. 5106 (January 30, 1998)

5. Cases:

In Home Health, Inc. v. Blue Cross and Blue Shield Association/Blue Cross & Blue Shield of Iowa, PRRB Dec. No. 96-D16, February 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,065, rev'd., HCFA Admin., October 28, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,942.

In Home Health Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 300,005 (D. Minn. June 16, 1998), aff'd, 188 F.3d 1043 (8th Cir. 1999), 1999-2 Medicare & Medicaid Guide (CCH) ¶ 300.326.

VNA of Maryland, LLC v. Blue Cross and Blue Shield Association/Cahaba Government Benefits Administrator, PRRB Dec. No. 2001-D39, August 8, 2001, Medicare & Medicaid Guide (CCH) ¶

80,729, rev'd, CMS Administrator, October 9, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,787.

Tulsa Home Health Services v. Mutual of Omaha Insurance Co., PRRB Dec. No. 2001- D44, August 30, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,734, rev'd., CMS Administrator, November 1, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,781.

Health Insurance Association of America, Inc. v. Shalala, 23 F.3d 412, (D.C. Cir. 1994), cert. denied, 513 U.S. 1147 (1995).

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1998).

High Country Home Health Care v. IASD Health Services Corp., PRRB Dec. No.97-D35, March 19, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,130, rev'd., HCFA Admin., May 20, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,543.

High Country Home Health Inc. v. Shalala, 84 F. Supp. 2d 1241 (D. Wyo. 1999), Medicare & Medicaid Guide (CCH) ¶ 300,411.

6. Other:

1997-1998 Homecare Salary & Benefits Report
Published by Hospital and Healthcare Compensation Services for the National Association for Home Care

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after consideration of the parties' contentions and evidence presented finds and concludes as follows:

The Provider employed physical therapists which it paid a lump sum for each patient visit performed. The Intermediary applied the salary equivalency guidelines contained in CMS Pub. 15-1 § 1400 to the therapists' compensation, thereby reducing the Provider's allowable program costs and reimbursement.

The Intermediary contends that applying the guidelines to the Provider's costs is appropriate based upon CMS Pub. 15-1 § 1403, which states:

> [i]n situations where compensation, at least in part, is based on a fee-for-service or on a percentage of income (or commission), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter.

In addition, the Intermediary also argued that its application of the guidelines to the Provider's physical therapy costs is also appropriate pursuant to Medicare's prudent buyer principles found at CMS Pub. 15-1 § 2103. Specifically, it is the Intermediary's position that, the fact that the Provider's physical therapy costs did exceed the guidelines proves that the costs are not reasonable and, in fact, substantially out of line.

The Board finds, however, that the Intermediary's application of the salary equivalency guidelines to the Provider's costs is improper. With respect to the Intermediary's first argument, the Board finds that 42 U.S.C. § 1395x(v)(5)(A), the controlling statute, distinguishes services performed by employees of a provider from services that are performed "under an arrangement" and indicates that the services performed by a physical therapist in an employment relationship with a provider are different from the services performed "under an arrangement." Both the legislative and regulatory history of the guidelines indicate that the guidelines were created to curtail and prevent perceived abuse in the practice of outside physical therapy contractors. The Board also notes that the term "under arrangement" is commonly referred to and used interchangeably with the term "outside contractor" guidelines. Accordingly, the Board finds the guidelines do not apply to employee physical therapists even though they are paid on a fee-for- service basis.

In support of its position, the Board cites In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th Cir. 1999) and High Country Home Health, Inc. v. Shalala, 84 F. Supp. 2d 1241 (D. Wy. 1999), finding, in part:

> 42 U.S.C. § 1395x(v)(5)(A) does not provide a basis for the application of the Guidelines to In Homes' employee physical therapists. The first part of the sentence in 42 U.S.C. § 1395x(v)(5)(A) explains that the subsection applies to persons providing physical therapy services "under an arrangement" with a provider. The second part of the sentence explains that the reasonable cost of compensation for the persons "under an arrangement" is calculated by reference to the salary which would
>
> have reasonably been paid to the person if that person had been in an "employment relationship" with the provider. The plain meaning of 42 U.S.C. § 1395x(v)(5)(A) and 42 C.F.R. § 413.106, which uses similar language, distinguishes between services provided "under an arrangement" and those provided by a person in an "employment relationship." It is clear from the language that a physical therapist who is "under an arrangement" is different from a person in an "employment relationship" with the provider. The Guidelines apply to a person "under an

> arrangement." The final notice in the Federal Register indicates that a person "under an arrangement" is an outside contractor. The Secretary's attempt to now further limit the term "employment relationship" to mean only salaried employees is not supported by the statute or the Secretary's contemporaneous interpretation as reflected in the 1992 regulation . . . . Thus, the statute requires nothing more than that a provider should be reimbursed for the services performed by a nonemployee, i.e., an outside contractor working under an arrangement with the provider, similarly to what an employer reasonably would pay its employee for such services. Services provided by a provider's employee are themselves subject to a reasonableness requirement. See 42 U.S.C. § 1395x(v)(1) . . . . We affirm the district court's reversal of the Secretary's decision and hold that the secretary may not apply the Guidelines to In Home's employee physical therapists.

With respect to the Intermediary's second argument, the Board finds that the guidelines should not be used in place of a prudent buyer analysis. Rather, intermediaries should determine whether or not a provider's costs are "substantially out of line" by a comparison of those costs to those incurred by other similarly situated providers. In the instant case, the Intermediary compared data from the Home Care Salary & Benefits Report (1997-1998) to the Provider's physical therapy costs in an effort to support its application of the guidelines under Medicare's prudent buyer concept. The Board notes that the Provider compiled survey data from three home health agencies in the Provider's area.

The 75th percentile of costs per visit for comparable agencies was $68.12, while the Provider's cost per visit was $ 68.23. In summary, the Board finds that the Provider's data was more accurate, and the Intermediary's data was not sufficient to support a reduction in the Provider's cost.

Finally, the Board notes that when the Secretary reissued the final guidelines in 1998, the guideline reimbursement rate for the Provider's specific locale was

$82.66. This contrasts to a guideline reimbursement rate of $55.18 for the year at issue. The new 1998 rate represents a 49.8 percent increase in one year over the applicable rate for the year in contention, from FYE 1997 to 1998. This lends further evidence to the argument that the old guideline reimbursement was insufficient.

DECISION AND ORDER:

The Intermediary's application of Medicare's salary equivalency guidelines to the compensation of physical therapists who were employed by the Provider but paid on a per-visit basis is improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Stanley J. Sokolove, CPA
Gary B. Blodgett, DDS

DATE OF DECISION: December 20, 2002

FOR THE BOARD:

Suzanne Cochran
Chairperson