PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D25

PROVIDER –
Tip of Illinois Health Services
Carterville, Illinois

Provider No. 14-7135

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Wellmark, Inc.

DATE OF HEARING -
January 13, 2004

Cost Reporting Periods Ended
December 31, 1993 and December 31, 1994

CASE NO(s). 96-1496 and 98-0237

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ISSUE:

Was the Intermediary's adjustment disallowing Medicare reimbursement for a portion of the Provider's physical therapy costs due to its application of physical therapy compensation guidelines proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This dispute arises out of a fiscal Intermediary's failure to reimburse a provider the amount it claims is due on a reasonable cost basis under the Medicare program of the Social Security Act 42 U.S.C. §§1395 et seq., for the 1993 and 1994 fiscal years. In order to participate in the Medicare program, a provider must file a provider agreement with the Secretary – 42 U.S.C. §1395cc. The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines established by the Centers for Medicare and Medicaid Services (CMS). At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs that are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice or program reimbursement (NPR). A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

This case concerns Wellmark's (Intermediary) use of physical therapy salary equivalency guidelines described and defined at §1861(v)(5) of the Social Security Act, 42 C.F.R. §413.106 and Chapter 14 of the Provider Reimbursement Manual (PRM).

Tip of Illinois Health Services (Provider) is a Medicare certified home health agency located in Carterville, Illinois. The Provider employed full and part-time physical therapists and aides to provide physical therapy services to its patients. It paid these physical therapists a salary for the work they performed. For any physical therapy visits furnished in excess of their required full-time services before November 15, 1994, the Provider paid the physical therapists and aides a commission.[1] All therapists and aides paid on a salary basis were subject to payroll withholdings and received fringe benefits as employees.

For providers paid on the basis of reasonable cost for cost reporting periods beginning on or after April 1, 1975, the basis for determining the reasonable cost of therapy services rendered by outside suppliers is limited to amounts equal 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 an allowance to compensate for other costs, such as travel

[1] See Intermediary Exhibit 1, Schedule CK-5A-1 (1994)

costs, that might be incurred in rendering services under arrangements. HCFA Pub. 15-1 §1400.

The Intermediary subjected the entire amount paid to the Provider's physical therapists and aides (both salaries and commissions) to Medicare's Physical Therapy Salary Equivalency Guidelines because a portion of the total compensation was based on a percentage of income (or commissions) paid by the Provider. The adjustments resulted in a reduction in Medicare reimbursement of $162,022 in 1993 and $148,064 in 1994.

The Provider appealed these adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Barbara E. Straub, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of BlueCross BlueShield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, Program Instructions, parties' contentions and evidence submitted, finds and concludes that the Intermediary improperly applied the physical therapy compensation guidelines to the payments made by the Provider to its therapists. It is undisputed that the therapists were employees of the Provider. The employees, regardless of the method of payment (salary, salary plus commission or a fee-for-service, were subject to the employer – employee relationship established by the Provider. The employees had federal taxes withheld and received W-2s. They also received fringe benefits typically received by employees.

The Intermediary applied the salary equivalency guidelines contained in CMS[2] Pub. 15-1 §1400 to the therapists' compensation, thereby reducing the Provider's allowable program costs and reimbursement. It contends that applying the guidelines to the Provider's costs is appropriate based upon CMS Pub. 15-1 §1403, which states in part:

> [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 non-salary arrangements, and the entire compensation will be subjected to the guidelines in this chapter.

The Board finds, however, that the Intermediary's application of the salary equivalency guidelines to the Provider's costs was improper. 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." The statute 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 indicate that these guidelines were created to curtail and prevent perceived abuses in the practice of outside physical therapy contractors. The Board also notes that the term "under arrangement" is

[2] Previously called Health Care Financing Administration (HCFA).

commonly referred to and used interchangeably with the term "outside contractor." Accordingly, the Board finds the guidelines do not apply to employee physical therapists even though they are paid a portion of their compensation on a fee-for-service basis. In support of its position, the Board agrees with the Provider's argument that In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th Cir. 1999) (In Home Health) and High Country Home Health, Inc. v. Shalala, 84 F. Supp.2d 1241 (D. Wy. 1999), support the premise that the Medicare law and regulations regarding physical therapy guidelines do not apply to in-house physical therapy staff. The In Home Health decision states in part:

> 42 U.S.C. §1395x(v)(5)(A) does not provide a basis for the application of the Guidelines to In Home's 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 reasonably have 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 non-employee, 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 subjected 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.

The Board further finds that the guidelines should not be used in place of a prudent buyer analysis. Rather, intermediaries should determine whether a provider's costs are "substantially out of line" by a comparison of those costs to costs incurred by other similarly situated providers. In the instant case, the Intermediary did not perform a prudent buyer analysis.

DECISION AND ORDER:

The physical therapy guidelines apply only to outside contractor compensation. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani

FOR THE BOARD

DATE: June 9, 2004

Suzanne Cochran
Chairperson