PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2004-D31

PROVIDER –
Pocono Medical Home Care, Inc.
East Stroudsburg, PA

Provider No. 39-7628

vs.

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

DATE OF HEARING –
June 9, 2004

Cost Reporting Period Ended
December 31, 1997

CASE NO. 99-3760

INDEX

	Page No.
Issue	**2**
Statement of the Case and Procedural History	**2**
Medicare Statutory and Regulation Background	**2**
Findings of Fact, Conclusions of Law and Discussion	**4**
Decision and Order	**6**

ISSUE:

Was the Intermediary's adjustment applying Medicare's Physical Therapy Compensation Guidelines to the Provider's employee physical therapists proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Pocono Medical Home Care, Inc. (Provider) is a freestanding home health agency located in East Stroudsburg, Pennsylvania. During its Medicare cost reporting period ended December 31, 1997, the Provider employed physical therapists who were paid based upon the number of home care visits they performed, i.e., they were paid on a "per visit" basis. Cahaba Government Benefit Administrators (Intermediary) reviewed the Provider's cost report for this period and applied Medicare's reasonable compensation guidelines to the cost of these physical therapists, which reduced the Provider's program reimbursement. The Provider appealed the application of the guidelines to "employee" physical therapist costs to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-.1841. The amount of program funds in controversy is approximately $32,000.[1]

The Provider was represented by Frederick C. Ingber of ZA Consulting, LLC. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries (intermediary or intermediaries) to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report and determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Board within 180 days of the NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

[1] Provider Position Paper at 1.

The Medicare Program reimburses providers for the reasonable costs they incur to furnish physical and other therapy services to Medicare beneficiaries. 42 U.S.C §1395x(v)(1)(A) provides, in part, that the reasonable cost of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The statute also authorizes the Secretary to establish cost limits. Essentially, the limits recognize reasonable costs based upon estimates of costs found to be necessary in the efficient delivery of covered items and services.

With respect to therapy costs, 42 U.S.C §1395x(v)(5)(A) states:

> Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, . . . the amount included in any payment to such provider or other organization under this subchapter as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services . . . to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses . . . incurred by such person, as the Secretary may in regulations determine to be appropriate.

The implementing regulation at 42 C.F.R. §413.106 states:

> (a) *Principle*. The 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. However, if the services of a therapist are required on a limited part-time basis, or to perform intermittent services, payment may be made on the basis of a reasonable rate per unit of service, even though this rate may be greater per unit of time than salary-related amounts, if the greater payment is, in the aggregate, less than the amount that would have been paid had a therapist been employed on a full-time or regular part-time salaried basis.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider employed physical therapists that it paid on a per visit basis. The Intermediary applied the salary equivalency guidelines contained in Medicare's Provider Reimbursement Manual, Part-I (HCFA Pub. 15-1) §1400 to the employee 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 HCFA 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 argued that its application of the guidelines to the Provider's physical therapy costs is appropriate pursuant to Medicare's prudent buyer principles found at HCFA Pub. 15-1 §2103. Specifically, it is the Intermediary's position that the fact that the Provider's physical therapy costs exceeded the guidelines proves that the costs are not reasonable and are, in fact, substantially out of line. 42 C.F.R. §413.9.

The Board finds that the Intermediary's application of the salary equivalency guidelines to the Provider's costs was 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 between physical therapy services performed by employees of a provider from those that are performed "under an arrangement." Both the legislative and regulatory history of the guidelines indicates that they 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." Accordingly, the Board finds the guidelines do not apply to employee physical therapists even though they are paid on a fee-for-service basis.[2]

Federal courts have also accepted the Board's rationale. In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th Cir. 1999) (In Home); High Country Home Health, Inc. v. Shalala, 84 F. Supp. 2d 1241 (D. Wy. 1999). The Court in In Home stated:

> 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

[2] There is no dispute in this case that the individual therapists at issue are "employees" of the Provider as opposed to outside contractors or suppliers.

> 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 the provider's costs to those incurred by other similarly situated providers. In the instant case, the Intermediary did not perform a prudent buyer analysis.

The Provider notes that the guidelines applied to its cost reports were outdated because they were developed from 1983 data. In SNI Home Care, Inc.,[3] the Board found that when CMS reissued guidelines in 1998, the guideline increased 49.8 percent over the rate that was in effect just one year earlier. The Board concludes that this supports the argument that the guideline amounts were insufficient and should not be used as an established "prudent buyer" limit.

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[3] In SNI Home Care, Inc. v. Blue Cross Blue Shield Association/Cahaba Government Benefit Administrators, PRRB Dec. No. 2003-D11, December 20, 2002, rev'd., CMS Administrator, February 13, 2003 (SNI Home Care, Inc.).

DECISION AND ORDER:

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

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, CPA
Anjali Mulchandani -West

DATE: July 16, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman