PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D63

PROVIDER -
Colorado Home Care, Inc.
Broomfield, Colorado

Provider No.: 06-7188

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit Administrators

DATE OF HEARING -
June 29, 2005

Cost Reporting Period Ended -
December 31, 1995

CASE NO.: 98-1913

INDEX

ISSUE:

Whether the Intermediary's adjustment applying the Adjusted Hourly Salary Equivalency Amount, (commonly referred to as the Salary Equivalency Guidelines (SEGs) or "physical therapy compensation guidelines") to fee-for-service employees compensation was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 administering the Medicare program. CMS' 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 Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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 to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

For the fiscal year ended (FYE) December 31, 1995, Colorado Home Care, Inc. (Provider) was a freestanding Medicare certified home health agency having its principal place of business in Broomfield, Colorado. During that time period, the Provider rendered home health services, including physical therapy services to its patients. The therapists performing physical therapy were employees of the Provider and were paid on a per-visit basis.

In its as-filed cost report, the Provider omitted from Worksheet A-8-3[1] salaries and visits performed by employee physical therapists paid on a per-visit basis. Wellmark,[2] the

[1] Intermediary Exhibit 1.

[2] Wellmark, Inc. subsequently was replaced by Cahaba Government Benefit Administrators as the Intermediary.

Provider's Intermediary for the period at issue, made an adjustment to include the visits and salaries of these employees on this worksheet and to subject the compensation paid to such employees to the SEGs.[3] The estimated Medicare reimbursement effect is $10,346.

The Provider appealed the adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Thomas L. Kirkland, Jr., Esquire and Julie A. Bowman, Esq. of Copeland Cook Taylor and Bush, P.A. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS

The Intermediary cites P.R.M.§1403 and the regulation at 42 C.F.R. §413.9 (c)(2) as support that therapists paid on a fee-for-service basis are subject to the SEGs and that costs should not exceed what a prudent and cost conscious buyer would pay. The Intermediary argues that the fact that the Provider's physical therapy costs exceeded the guidelines proves that the costs were not reasonable. Moreover, the Intermediary points out that the Administrator's decision in SNI Home Care v. Blue Cross Blue Shield Association/Cahaba Government Benefit Administrators,[4] supports the Intermediary's position.

The Provider disagrees with the Intermediary's application of the SEGs to its employees on three bases. First, the Provider argues that its costs were reasonable (2.5% over the maximum allowable compensation per the SEGs). Second, applying the SEGs to employees contradicts 42 U.S.C. §1395x(v)(5)(A), 42 C.F.R. §413.106 and P.R.M. §1403, as these provisions apply to services provided "under arrangement." Third, the Provider's position is consistent with decisions of the PRRB, District Courts, and the Eighth Circuit Court of Appeals. The Provider noted that it was not until 1998, three years after the cost report period in dispute here, that CMS revised the regulations to apply the SEGs to employee therapists who are compensated on a fee-for-service or on a percentage of income basis.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, evidence and the parties' contentions, finds as follows:

The Intermediary improperly adjusted the Provider's cost report by applying the SEGs for therapy services provided "under arrangement" by outside contractors to the wages paid to the Provider's employee therapists. The Intermediary does not dispute that the therapists were employees of the Provider, but maintains that, according to Medicare program instructions, the application of the guidelines is appropriate based on P.R.M.§1403, which states in part:

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[3] Intermediary Exhibit 2, Provider Exhibit 2.

[4] PRRB Dec. No. 2003-D11, December 20, 2002, Medicare and Medicaid Guide (CCH) ¶80,959, rev'd., CMS Administrator, February 13, 2003, CCH ¶80,973

> [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.

The Board concurs with the Provider's position and the decisions of numerous courts that have heard this legal dispute. The Board finds compelling the rationale expressed against the application of physical therapy guidelines to in-house physical therapy staff by the U.S. District Court in In Home Health, Inc. v. Shalala, 97-2598 (D. Minn. June 16, 1998). The Court stated in part:

> . . . the Act clearly states that physical therapy services performed "under an arrangement" do not include services performed by a physical therapist in an employment relationship with the provider. 42 U.S.C. §1395x(v)(5)(A) reads:
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> > Where physical therapy services ... 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 . . . as the reasonable costs 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). . . . (Emphasis added).
>
> The language of the Act distinguishes between services that are performed by employees of the provider and services that are performed "under an arrangement," and it indicates that services performed by a physical therapist in an employment relationship with the provider are different from those services performed "under an arrangement." The Guidelines, therefore, do not apply to employee physical therapists who are paid on a fee-per-visit basis.

The decision of the district court was subsequently affirmed by the U.S. Court of Appeals for the Eighth Circuit.[5]

The Board further finds that the SEGs should not be used in place of a prudent buyer analysis. In order to apply the prudent buyer principle, the Intermediary is required to

[5] No. 98-3141, September 1, 1999.

determine whether a provider's costs are "substantially out of line" by comparing those costs to costs incurred by other similarly situated providers. 42 C.F.R. §413.9(c)(2). In the instant case, the Intermediary did not perform a prudent buyer analysis but attempted to use the SEGs as a substitute for a prudent buyer analysis. The Board finds that the use of the SEGs is not a substitute for the analysis required by the regulation. Moreover, the Provider's argument that its costs were reasonable was persuasive.

DECISION AND ORDER:

The Intermediary improperly applied the SEGs to the Provider's employed physical therapists who were paid on a fee-for-service basis. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIAPTING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

DATE: September 1, 2005

FOR THE BOARD:

Suzanne Cochran
Chairperson