PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D6

PROVIDER -
Professional Home Care, Inc.
Garvin and Moore, Oklahoma
Professional HC 97 Access Infusion Group

Provider Nos.: 37-7120 and 37-7417*
(*Only 2 providers in group)

vs.

INTERMEDIARY
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
May 21, 2004

Cost Reporting Periods Ended -
January 31, 1995; January 31, 1996;
January 31, 1997 and January 31, 1998

CASE NOs. : 97-2444; 98-2580, 99-3445;
99-3383G (group) and 00-1426

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ISSUES:

1. Whether the adjustments to the Providers' physical therapy costs were proper – applies to Case Nos. 97-2444, 98-2580, 99-3445 and 00-1426.

2. Whether the adjustments to the Providers' travel costs were proper – applies to Case Nos. 97-2444 and 98-2580.

3. Whether the adjustments to the Providers' home infusion costs were proper – applies to Case Nos. 99-3383G and 00-1426.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Professional Home Care, Inc. (Providers) consists of two Medicare-certified home health agencies (HHAs) located in Garvin and Moore, Oklahoma. The Providers also have a corporate home office in Moore, Oklahoma. The Providers submitted cost reports for the fiscal years ended January 31, 1995 through January 31, 1998. Cahaba Government Benefit Administrators (Intermediary) adjusted the Providers' cost reports to reduce their claims for physical therapy, travel and home infusion costs. The Providers appealed the adjustments to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841. The amount of Medicare reimbursement in controversy is approximately $75,000 for physical therapy; $24,000 for travel; and $60,000 for home infusion.

The Providers were represented by John W. Jansak, Esquire, of Harriman, Jansak & Wylie. The Intermediary was represented by James Grimes, Esquire, of 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 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,

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.

Issue 1 – Physical Therapy Costs

The Medicare Program reimburses providers for the reasonable costs they incur to furnish physical and other therapy services to Medicare beneficiaries. The statute at 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, the statute at 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 in relevant part:

> *(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.

During the fiscal years under appeal, the Providers furnished physical therapy services to Medicare and non-Medicare patients. The Providers submitted 100 percent of the physical therapy costs and visits on worksheet A-8-3 of their Medicare cost reports for each year under appeal. The Intermediary reduced the number of hours submitted on worksheet A-8-3 to equal one hour per visit because the Providers could not provide documentation to support more than one hour per visit. In addition, the Intermediary adjusted the physical therapy cost limits to those published in the Federal Register. These adjustments reduced reimbursement for physical therapy services furnished by the Providers employees by applying the Medicare program's salary equivalency guidelines for physical therapy pursuant to 42 C.F.R. §413.106.

The Providers furnished physical therapy services through employees with whom they had contracts under which they were paid on a per-visit basis. The Intermediary reviewed financial records indicating that the Providers incurred salary expenses, benefit expenses in the form of insurance and taxes, auto and travel expenses, contracted expenses and training expenses for these employees. The financial statements indicated that physical therapy services were provided by both employed physical therapists and contracted physical therapists. Based on documentation available to the parties, they stipulated to the split of costs and visits between employed and contracted physical therapy services. See Stipulation of Facts dated March 31, 2004.[1]

PARTIES' CONTENTIONS

The Providers acknowledge that 42 U.S.C. §1395x(v)(5)(A) allows the Secretary to set cost limits for physical therapy services furnished "under an arrangement." The Providers contend, however, that these services were performed by its employees under Internal Revenue Service (IRS) definitions and it should not matter that they were paid on a "per-visit" basis. The Providers also assert that the amounts paid were reasonable and not out of line with compensation paid by comparable providers. The Providers argue that the physical therapy guidelines had not been properly revised for many years until fiscal year 1998, and thus the per-visit limits for the years under appeal were unreasonably low. When the rates were revised in January of 1998,[2] they were increased

[1] Provider Exhibit 7; Case No. 99-3445.
[2] Provider Exhibit 2; Case No. 00-1426.

by about 42 percent to $73.95.[3] The Providers point out that their rate of $64.39 for fiscal year 1998 was 20 percent lower than the revised rate and therefore reasonable.[4]

The Intermediary asserts that CMS Pub. 15-1 §1403 requires it to treat situations where compensation is based in part on a fee-for-service basis as non-salary arrangements subject to the guidelines. The Intermediary also argues that the Providers' costs were substantially out of line because their costs for physical therapy services exceeded the guidelines.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

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

The Board finds that the guidelines should not be applied to the Providers' employees. The Board, however, does not consider the physical therapists employed through a contract to be employees of the Provider even though the Provider paid for their employee benefit costs. Therefore, the application of the guidelines to these visits was appropriate.

With respect to the Providers' physical therapist employees, the Board notes that the Providers paid both their employees and contractors on a per-visit basis. The Intermediary applied the salary equivalency guidelines contained in CMS Pub.15-1 §1400 to the employee therapists' compensation, thereby reducing the Providers' allowable program costs and reimbursement.

The Intermediary contends that applying the guidelines to the Providers' employee 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 argues that its application of the guidelines to the Providers' physical therapy costs is 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 Providers' 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 Providers' employees 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 physical therapy services performed by employees of a provider from those

[3] Providers Exhibit 2; Case No. 00-1426.
[4] Providers Exhibit 1; Case No. 00-1426.

that are performed "under an arrangement." Both the legislative and regulatory history of the guidelines indicate 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 that the guidelines do not apply to employee physical therapists even though they are paid on a fee-for-service basis.

Federal courts have also accepted the Board's rationale. See 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 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 Providers note that the guidelines applicable to their cost reports were outdated because they were developed from 1983 data. The Board agrees that when CMS reissued guidelines in 1998, the guideline for Oklahoma increased from $52.44 to $73.95, or approximately 42 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. See 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.

Issue 2 – Travel Costs

The Providers claimed the travel costs incurred by their owner and chief executive officer (CEO) for travel from the home office where his position was located in Moore, Oklahoma, a suburb of Oklahoma City, to its facility site in Pauls Valley, Oklahoma. The distance between the sites was stated to be 45 miles with a travel time of one hour. Tr. at 20. Due to the extent of business at the Pauls Valley facility, the CEO often stayed there for 3 or 4 nights per week. The CEO claimed travel costs to the Pauls Valley facility, including gas expenses and hotel costs, for 45 weeks in fiscal year 1995 and 23 weeks in 1996. Tr. at 43.

The Intermediary reviewed the CEO's hotel expense and disallowed the cost because it was not prudent for the CEO to incur hotel expenses when staying in a town within a reasonable driving distance from his residence. Additionally, the Intermediary viewed the mileage cost claimed as commuting costs and, therefore, disallowed those costs as well.

PARTIES' CONTENTIONS:

The Providers assert that the travel expenses should be handled under IRS rules that permit travel expenses if one is temporarily away from home overnight for business purposes. Since the CEO's home was where the corporate home office was located, travel expenses to the Pauls Valley facility should be permitted. In addition, since the CEO had to visit the Pauls Valley facility for several days each week and it was an hour each way to that facility, it would necessitate two hours in travel time each day. The Providers assert that it was not reasonable or necessary for the CEO to return home each night.

The Intermediary claims that it made its audit adjustments to the Providers' travel costs in accordance with 42 C.F.R. §413.9 – Cost Related to Patient Care and Provider Reimbursement Manual (PRM) Sections 2102.1 – Reasonable Costs, Section 2103 – Prudent Buyer and Section 2114.2 – Transportation Costs. The Intermediary notes that on several occasions, the CEO would travel to Pauls Valley, return to Moore, and then return to Pauls Valley on the same day. The Intermediary contends the two offices were driving distance and it was not unreasonable to expect the CEO to return home on the same day instead of incurring unnecessary hotel expenses. In addition, the Intermediary

argues that the CEO's travel patterns suggest that the mileage costs were commuting expenses, which is not a Medicare reimbursable cost.

FINDINGS OF FACT,CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board recognizes that the CEO may need to visit branches on a routine basis to ensure their operational efficiency. However, it does not find adequate justification for the CEO to visit the Pauls Valley facility on an almost daily basis, almost every week, when his purported work site is in the corporate home office. The Board also finds that the short distance between the Pauls Valley facility and the home office is considered a normal commuting distance. The Board, therefore, finds that the Intermediary adjustments denying the CEO's travel costs are proper.

Issue 3 – Home Infusion Costs

The Providers provide intravenous (IV) services to both Medicare and non-Medicare patients in their homes. Although Medicare covers the cost of coordinating and administering IV drugs, i.e, the cost of the IV visit, Medicare does not pay for the cost of the IV drugs. Home Health Agency Manual (Pub. 11) §205.1B4. For non-Medicare patients, insurers typically pay for the cost of the IV visit and the IV drugs. Because of the difference in coverage, the Providers had different billing procedures for Medicare and non-Medicare patients for IV services. For Medicare patients, the Providers billed Medicare for the IV visit, and the patients had to pay the pharmacy for IV drugs out of their own pockets. For non-Medicare patients, a separate corporation called "ACCESS" was set up in the home office. ACCESS billed insurers for the IV drugs and the IV visits. ACCESS subcontracted with and paid the Providers for the IV visits and paid the pharmacies for the IV drugs. For both Medicare and non-Medicare patients, the IV drugs were either delivered directly to the patient's home by the pharmacy or were picked up by the Providers' staff on their way to the IV visits. In neither case did the Providers store or maintain IV drugs at their facilities.

The Providers did not claim any costs associated with ACCESS on the home office cost statement. Instead, in order to apportion the IV infusion service costs between Medicare and non-Medicare patients, the Providers included all of the costs in their cost reports. These cost included salaries, benefits and drug costs. During the audit, the Intermediary made an adjustment placing all costs associated with ACCESS IV visits in a non-reimbursable component on schedule G of the home office cost statement. The Providers and the Intermediary subsequently entered into an administrative resolution in which the salary and benefit costs portion of the adjustment was reversed. Thus, the only unresolved issue is the proper treatment of the cost of the IV drugs related to these visits. Because the IV drug costs remained in a non-reimbursable cost center as a statistic on the home office statement, they were then apportioned overhead costs from the pooled overhead costs. The total amount of pooled overhead cost allocated to the non-

reimbursable cost center set up for ACCESS, and thus disallowed, was approximately $66,000. Tr. at 134.

PARTIES' CONTENTIONS:

The Providers assert that the IV drugs used for ACCESS patients should not be treated as the cost of goods sold. The Providers state that they did not inventory the IV drugs and that the IV drugs were ordered by the patients' physicians and prepared by independent pharmacies. The function of ACCESS is to pay for the IV drugs by writing checks to the pharmacies, to pay the Providers to conduct the visits and to bill the third party insurer. The Providers note that their staff sometimes pick up the IV drugs from the pharmacy on the way to the visit, but that they also do this for Medicare patients. The Providers claim that ACCESS is basically a shell company without employees and that the providers merely write a small number of checks. The Providers assert that the allocation of $66,000 in overhead costs to this minor activity is inappropriate and amounts to inappropriate shifting of costs from the Medicare program.

The Intermediary contends that the Providers' home office supported both the Medicare-certified HHAs and other health related entities, including ACCESS. Therefore, general overhead costs must be allocated to the various components. The Intermediary notes that the method of allocation is specified in CMS Pub. 15-1 §2150.3. The manual allows both direct and functional allocation of costs where the costs that relate to specific components are identifiable. Where these costs are not identifiable, costs are allocated from the pooled costs to the various components based on the total costs of the components. Since the Provider has not allocated any overhead costs to ACCESS based on either the direct or functional method, the Intermediary, under the manual instructions, must allocate costs to ACCESS based on the total costs of the components.

The Intermediary argues that it is appropriate to treat the cost of IV drugs as cost of goods sold because they were obtained and paid for by ACCESS for its patients. As a component of that service, the cost of IV drugs needs to be included in the total cost statistic on schedule G of the home office cost report. The Intermediary also rejects the Providers' assertion that the only cost associated with ACCESS was the writing of a few checks. The Intermediary claims that ACCESS was organized as a separate corporation legally and functionally and that there had to be costs to establish the corporation, set up contracts, bill insurers and to pay pharmacies and the Providers. The Intermediary disputes the Providers' claim that the only cost that ACCESS incurred was for writing a few checks. Since the Providers have not made any direct or functional allocation to ACCESS, the Intermediary must allocate overhead based on total costs of goods sold. CMS Pub. 15-1 §2150.3D.2(b).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board agrees that ACCESS is a separate legal entity in the home office that must be treated as a non-reimbursable cost center. The Board also finds that the Providers' involvement in the billing and payment for the IV drugs makes it appropriate to treat them as cost of goods sold for the purpose of allocation of overhead costs. The Board is sympathetic to the Providers' argument that the high cost of these drugs may not reflect the actual amount of time and effort spent by the home office in paying for the drugs, billing third parties for the cost of the drugs and paying the Providers for delivery of the IV visits; however, the Board agrees with the Intermediary that it is impossible that no employee time or expense is associated with operating ACCESS. The Board finds that the Providers could have identified these costs and directly or functionally allocated them to a non-reimbursable cost center. Since the Providers did not use a more sophisticated method to identify and allocate these costs, the Board finds the Intermediary's use of IV drugs as the cost of goods sold to be proper.

DECISION AND ORDER:

Issue 1 – Physical Therapy Costs:

The Intermediary's application of Medicare's salary equivalency guidelines to the compensation of physical therapists that were employed by the Providers but paid on a per-visit basis was improper. The Intermediary's application of the guidelines to the Providers' contract employees was proper. The Intermediary's adjustments are reversed for its salaried employees and affirmed for contract employees.

Issue 2 - Travel Costs:

The Intermediary's adjustments disallowing the CEO's travel costs were proper. The Intermediary's adjustments are affirmed.

Issue 3 – Home Infusion Costs:

The Intermediary's adjustments to the Providers' home infusion costs were proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: November 18, 2005

Suzanne Cochran, Esquire
Chairman