PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D18

PROVIDER -
The Medical Team
Reston, Virginia

Provider No.: 49-7033

vs.

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

DATE OF HEARING
December 6, 2005

Cost Reporting Periods Ended -
March 31, 1996 and March 31, 1997

CASE NOs.: 00-0548 and 00-0609

INDEX

ISSUE:

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

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative 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 portion 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 NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Medicare reimbursement is governed by section 42 U.S.C §1395x(v)(1)(A) of the Social Security Act (Act). In part, the statute provides 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 of DHHS 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:

> [w]here 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. (Emphasis added.)

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 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 the therapist been employed on a full-time or regular part-time salaried basis.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Medical Team (Provider) is a home health agency (HHA) located in Reston, Virginia. It is a member of a chain of HHAs with related Medicaid, private care, and homemaker business activities. During its Medicare cost reporting periods ended March 31, 1996 and March 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 reports for each of these periods and applied Medicare's reasonable compensation guidelines (limits) authorized pursuant to 42 U.S.C §1395x(v)(5)(A) and 42 C.F.R. §413.106 discussed above, to the cost of these therapists, thereby reducing the Provider's program reimbursement. The Provider appealed the application of the guidelines to "employee" physical therapist costs to the Board pursuant to 42 C.F.R. §§405.1835-.1841 and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $59,836 ($41,380 in 1996 and $18,456 in 1997).[1]

[1] Intermediary's Position Paper dated May 20, 2004, at 5 and 4.

The Provider was represented by John W. Jansak, Esq., of Harriman, Jansak & Wylie. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the pertinent statute and regulation establishes guidelines applicable to therapy services furnished under arrangements, which means services performed by outside contractors and not employees. The Provider acknowledges that Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §1403 requires that the guidelines be applied to employees paid on a fee-for-service basis. However, the Provider cites In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th. Cir. 1999) aff'ing., In Home Health v. Blue Cross Blue Shield Association et. al. PRRB Dec. No. 96-D16, February 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,065, where the Board found no authoritative basis for applying the guidelines to employees.[2] In addition, the Provider contends that its 1996 cost per visit was not out of line with the compensation paid by comparable providers based upon the physical therapy guidelines published by CMS on January 30, 1998.[3]

The Intermediary contends that the therapy guidelines apply to the Provider's therapists who where paid on a per visit basis according to HCFA 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 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 Intermediary also contends that the fact the Provider's physical therapy costs exceeded the physical therapy guidelines proves they are out of line with the costs of other providers; therefore, these costs are unreasonable pursuant to Medicare's prudent buyer provisions. 42 C.F.R. §413.106(c)(5), HCFA Pub. 15-1§1403, 42 C.F.R. §413.9(c)(2).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

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

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[2] Provider's Final Position Paper at 3.
[3] Provider's Supplemental Position Paper at 3.

The Board finds that the Intermediary's application of the guidelines to the Provider's costs is improper. 42 U.S.C. §1395x(v)(5)(A), the controlling statute, distinguishes services performed by employee therapists from services performed by outside contractors "under an arrangement" with a provider. Both the legislative and regulatory history of the guidelines indicate that the guidelines were created to prevent perceived abuse in the practices of outside physical therapy contractors as opposed to provider employees. Moreover, the Board notes that the term "under an 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.

As noted in previous cases, the Board cites the 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.

The Board also finds that the guidelines alone can not be used to adjust a provider's costs in accordance with Medicare's prudent buyer principle. Rather, 42 C.F.R. §413.9 indicates that intermediaries must determine whether or not a provider's costs are "substantially out of line" or are unreasonable based upon a comparison of those costs to those incurred by other similarly situated providers.

DECISION AND ORDER:

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

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Elaine Crews Powell, C.P.A

FOR THE BOARD:

DATE: March 3, 2006

Suzanne Cochran, Esq.
Chairman