# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D8

**PROVIDER** –
Visiting Nurse Association of Texas
Dallas, Texas

Provider No.: 45-7001

**vs.**

**INTERMEDIARY –**
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

**DATE OF HEARING –**
April 27, 2006

Cost Reporting Period Ended -
June 30, 1997

**CASE NO.:** 99-3188

**INDEX**

ISSUES:

ISSUE 1: Whether the disallowance of $595,069 as an adjustment to administrative and general pooled costs related to a management service organization, Home Health First, was proper.

ISSUE 2: Whether the disallowance of $35,390 to remove the portion of Home Health First management fees attributable to the cost of a deferred compensation plan for executives was proper.

ISSUE 3: Whether the disallowance of $351,012 as cost in excess of the physical therapy salary equivalency guidelines (SEGs) was proper (on the record).

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. §1395h, 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

On November 6, 1998, Palmetto Government Benefit Administrators (Intermediary) issued Visiting Nurse Association of Texas, Inc's. (Provider) fiscal year ending June 30, 1997 NPR. The Provider filed an appeal with the Board on April 15, 1999. On January 4, 1999, the Intermediary issued a revised NPR and the Provider also appealed this revised NPR on July 1, 1999. The PRRB consolidated the two appeals into this single

case. The Provider met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

The Provider was represented by William A. Dombi, Esq., Director, Center for Health Care Law. The Intermediary was represented by Bernard M. Talbert, Esq. Associate Counsel, Blue Cross Blue Shield Association.

ISSUE 1: BACKGROUND:[1]

The Provider, Baylor Health Care System (Baylor) and Presbyterian Health Care System (Presbyterian), through a Letter of Intent dated May 4, 1995, created Home Health First (HHF), a home health management company. HHF was organized as a Texas not-for-profit corporation with its principal office in Dallas, Texas.

In conjunction with the creation, organization, and operation of HHF, the Provider contributed $332,321 in FY 1996 and $262,748 in FY 1997 (for a total of $595,069) to capitalize HHF. Up through June 30, 1997, these payments were reflected on the Provider's Financial Statement Balance Sheet as "Investment in Home Health First."

In January 1996, the Provider contracted with HHF for services[2] necessary to the Provider's operation of its Medicare participating home health agency. The parties stipulated that these services were provided and that if HHF had not provided such services, the Provider would have required the same services be performed on either an "in-house" or "out-sourced" basis.

HHF was disbanded effective October 1, 1997. The Provider's consolidated financial statements stated:[3]

> A wind-down period has ensued and eventually all the assets of HHF will either be liquidated and/or transferred to the three partners [VNA, Baylor, Presbyterian] after satisfying all obligations of HHF. As a result, management estimates that VNATX [Provider] will realize no value from the investment in HHF. Therefore VNATX has charged 1997 operations with a loss on the write-down of the

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[1] The parties filed extensive stipulations addressing the pertinent background and facts as outlined in this decision (see Provider Exhibit P-15).

[2] The services under the agreement with HHF included: Clinical Management, Accounting and Finance, Payroll, Accounts Receivable and Payable, Billing and Collections, Human Resources, Information Services, Quality Management, Risk Management, Staff Development and Education, Purchasing, Telecommunications, Consulting, Administrative Support, Local, State and Federal Permit and Licensing, Management of Written Office Policies and Procedures, and New Program Development.

[3] Intermediary Exhibit I-2 at p. 2. See also Provider Exhibit P-17 at p.12.

> investment in HHF totaling $595,069 and as such, the carrying value of the investment in HHF is zero at June 30, 1997.

Accordingly, the Provider's amended cost report for FYE June 30, 1997 included a claim for such $595,069 loss in the Administrative and General (A&G) cost center. The Intermediary disallowed the claim.

ISSUE 1-PARTIES' CONTENTIONS

The Intermediary contends that the Provider has not provided sufficient documentation to support that the $595,069 expenses at issue were related to patient care activities or allowable management fees in accordance with the requirements of 42 C.F.R. §§413.9 and 413.24.[4]

The Provider contends that the Intermediary's original basis for the disallowance of the cost of services secured through HHF was the characterization of these costs in its financial statements as a loss on the write-down of the "investment in HHF." The Provider argues that these costs were for management fees that it incurred during fiscal year 1997 and should be allowed because a liability was accrued consistent with generally accepted accounting principles. Although in its financial statements, the Provider referred to the $595,069 as an investment, and the Intermediary disallowed the costs as an investment write-off, the parties stipulated that the cost is not an "investment," as contemplated by CMS Pub. 15-1, §202.2. The parties further stipulated that VNA liquidated any charges for costs in excess of the preset monthly charge by HHF during fiscal year 1997 or a short time thereafter.

The Provider contends that, at the hearing, the Intermediary recharacterized its basis for the disallowance by arguing that the Provider failed to present adequate documentation to support that the cost was incurred during 1997. The Provider notes that after the appeal was filed, HHF dissolved as a corporate entity and a fire destroyed the Provider's office building and virtually all of the contents, including any records regarding HHF costs. The Provider submits that it would be fatally prejudiced by the Intermediary's shift of position if the Board allows for this change in basis for the disallowance.

ISSUE 1-FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board finds that the Intermediary's adjustment was proper. The Provider has not adequately tied the $595,069 to specific allowable expenses in accordance with 42 C.F.R. §§413.20 and 413.24.[5] While the Board acknowledges the Provider's allegation that it

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[4] See Transcript (Tr.) at 23-25.

[5] 42 C.F.R. §413.20(a) states, in relevant part, "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program." 42 C.F.R. 413.24(a) states that Providers receiving payment on the basis of reimbursable cost must provide adequate

was misled by the characterization of the Intermediary's adjustment, the Board finds that the Provider had notice that adequate documentation was needed to support the expenses claimed. When it made its adjustment, the Intermediary's subcontractor, HR&S, stated:

> HR&S is contending that this is a FY 98 expense, not FY 97, thus the reason to offset in FY 97. If proper documentation is received, an amount should be added back on the FY 98 cost report.[6]

ISSUE 2- BACKGROUND:

The Provider submitted an amended cost report identifying $5,366,585 for HHF pooled management fees. The Intermediary disallowed $35,390 of such amount.

Specifically, the parties stipulated that during the FYE June 30, 1997, HHF had as part of its executive staff retirement benefits, the FLEX Retirement Options, capital accumulation account (CAA). The non-qualified[7] executive benefits plan was established by HHF on April 1, 1997 and included the establishment of a trust, managed and held by a third party benefits administrator. The Plan's participants established contribution schedules, had specified vesting rights, and full control over the exercise of the investment options under the plan. The official description of the CAA[8] states, in relevant part:

> Substantial risk of forfeiture: As required by the IRS, the CAA is subject to a substantial risk of forfeiture in the form of a noncompetition agreement which stipulates that you will not work for a competitor (any health care entity that is not owned by HHF) within a geographical area as described in the agreement, in the same or similar job duties for a period of 24 months. If you violate the noncompetition agreement, you forfeit your undistributed balance in the CAA . . .
>
> Employer insolvency. HHF owns the investments of the CAA until your distribution date. Based on IRS rules, if HHF becomes insolvent, you will be an unsecured creditor and will have no preferred claim to any assets. However, special trust has been implemented to safeguard your CAA from any other contingencies such as change of control of HHF.

While the parties stipulated that the dispute is controlled by CMS Pub. 15-1 §2140, the parties disagree as to whether under §2140.3 the plan provides for the protection of the

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cost data. This must be based on financial and statistical records which must be capable of verification by qualified auditors. . . ."

[6] Intermediary Exhibit I-4 at 3.

[7] For purposes of Section 401 of the Internal Revenue Code of 1986.

[8] Provider Exhibit P-3 at 3.

plan's assets. The parties further stipulated that the deferred contribution plan met all other CMS Pub. 15-1 §2140.3 requirements.

ISSUE 2: PARTIES' CONTENTIONS

The Provider contends that the existence of a trust which was held and managed by a third party administrator, combined with the structure of the plan (which included a schedule of contributions, specific vesting rights, and full control over the exercise of investment options by plan participants) satisfies the requirement that the assets were sufficiently protected. The plan contained commonly used, non-onerous risks to qualify for a tax liability deferral in accordance with IRS standards.[9] As the overall context of CMS Pub. 15-1 §2140 et seq. is to set conditions for the allowability of costs related to non-qualified deferred compensation plans, the IRS' standards, which incorporate the necessity of some risk, must be considered when interpreting the program manual.

The Intermediary argues that because the fund could be reached by general creditors if HHF become insolvent and because participants were at risk for losing their contributions if they violated a non-compete clause the assets are not properly safeguarded pursuant to CMS Pub. 15-1 §2140.3C.1. (which requires that all the plan's assets be distributed exclusively to participating employees and their beneficiaries).

ISSUE 2: FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION

The Board finds that the Intermediary's disallowance is improper.

CMS Pub. 15-1 §2140 entitled Deferred Compensation states, in relevant part:

> 2140.1. Definition—Deferred compensation is renumeration currently earned by an employee but which is not received until a subsequent period, usually after retirement. Accordingly, a deferred compensation plan defers the receipt of income beyond the year in which it is earned. The type of deferred compensation plan considered herein is not considered a qualified plan under Internal Revenue Service requirements (See subchapter D, Internal Revenue Code of 1986, as amended, and regulations thereunder.) Qualified deferred compensation plans generally meet the definition of a pension plan and are treated under §§2142ff or, in the case of qualified defined contribution deferred compensation plans §§2141ff.
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> 2140.3.C.1.— . . . All assets accumulated by the plan must be distributed exclusively to the participating employees or their beneficiaries.

[9] Internal Revenue Code, 26 U.S.C. §457(f) et seq.

CMS Pub. 15-1 §2141.3 also states that a formal deferred compensation plan is a "permanent plan which . . . provides for the protection of the plan's assets."

The parties do not dispute that the plan was a non-qualified deferred compensation plan. The IRS rules establish that a core element of such a plan is the existence of "a substantial risk of forfeiture of the rights to such compensation." The Provider has demonstrated that this plan's risks (insolvency and violation of a non-competition clause) are general risks typically incorporated in non-qualified plans to defer tax liability pursuant to IRS rules. However, no evidence exists that the plan was not adequately safeguarded. The Board agrees that because the overall context of CMS. Pub. 15-1 §2140 et seq. is to set conditions for non-qualified deferred compensation plans, the IRS standards which incorporate risk, may be considered.

ISSUE 3: BACKGROUND:

The parties stipulated that the physical therapy services in dispute were provided by physical therapists who were employees of the Provider paid on a per-visit basis (as opposed to on a salary basis).[10] The Intermediary disallowed $351,012 of costs in excess of the physical therapy salary equivalency guidelines (SEGs).

ISSUE 3: PARTIES' CONTENTIONS**:**

The Provider contends that pursuant to 42 U.S.C. §1395x(v)(5)(A) and 42 C.F.R.§413.106, the SEGs only apply to services furnished under arrangements, i.e., services performed by outside contractors. Likewise, CMS Pub. 15-1, §1400 entitled Reasonable Costs of Therapy and Other Services Furnished by Outside Providers, and §1403[11] limit the application of the SEGs to services provided by outside suppliers as

[10] Additionally the parties stipulated that there is no dispute as to the reasonableness of the compensation outside of the issue concerning the applicability of the Physical Therapy Salary Equivalency Guidelines (SEGs). An objective test of reasonableness is measured by the fact that the paid compensation was less than the amount that would have been paid under the physical therapy SEGs that became effective as of April 11, 1998 if applied retroactively to FYE 6/30/97.

[11] CMS Pub. 15-1 §1403 states, in relevant part, "The guidelines apply only to the costs of services performed by outside suppliers, not the salaries of providers' employees. However, the costs of the services of a salaried employee who was formerly an outside supplier of therapy or other services, or any new salaried employment relationships, will be closely scrutinized to determine if an employment situation is being used to circumvent the guidelines. Any costs in excess of an amount based on the going rate for salaried employee therapists must be fully justified. 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 non-salary arrangements, and the entire compensation will be subject to the guidelines in this chapter."

opposed to employees. The Provider further cites the Eighth Circuit Court of Appeal's decision In Home Health, Inc. v. Shalala,[12] as further support.

The Intermediary contends that CMS Pub. 15-1 §1403 reflects CMS's longstanding policy that where compensation to physical therapists is made on a fee-for-service basis, such compensation is considered like an "under arrangement" situation and the guidelines would apply despite the existence of an "employee" relationship. The Intermediary also contends that because the Provider is located outside of the Eighth Circuit, the In Home Health decision is not controlling in this case.

ISSUE 3: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary's application of the SEGs to the Provider's physical therapy costs was improper.

The statute at 42 U.S.C. §1395x(v)(1)(A) 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 in relevant part:

> *Principle*. The reasonable cost of the services of physical, occupational, speech, and other therapists, and services of other

[12] 188 F.3d 1043 (8th. Cir. 1999).

> 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. . . .

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 history and regulatory history of the guidelines indicate that they 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 per-visit basis.

The Board's inclusion is consistent with decisions in two Federal courts. In In Home Health, Inc. v. Shalala,[13] the Eighth Circuit Court stated:

> . . . 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 . . . furnished "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

[13] Id. See also High Country Home Health, Inc. v. Shalala, 84 F. Supp. 2d 1241 (D.Wy. 1999).

> relationship" to mean only salaried employees is not supported by the statute or the Secretary's contemporaneous interpretation as reflected in the 1992 regulation.
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> * * * * *
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> 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).
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> * * * * *
>
> 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 similarly situated providers. In this case, the parties stipulated that there is no dispute as to the reasonableness of the compensation outside the issue concerning the applicability of the physical therapy salary equivalency guidelines; accordingly, such costs are allowable.

DECISION AND ORDER:

ISSUE 1: The disallowance of $595,069 in A&G pooled costs related to HHF was proper. The Intermediary's adjustment is affirmed.

ISSUE 2: The disallowance of $35,390 to remove the portion of HHF attributable to the cost of the deferred compensation plan was improper. The Intermediary's adjustment is reversed.

ISSUE 3: The Intermediary's application of the SEGs 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, Esquire
Anjali Mulchandani- West, C.P.A.
Yvette C. Hayes

RECUSED: Elaine Crews Powell, C.P.A.

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: November 16, 2007