PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D46

PROVIDER –
HHS/AllCare 93-94, 96 PT Group Appeal
Denver, Colorado

Provider No. 06-7032 and 06-7201

vs.

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

DATE OF HEARING-
August 8, 2001

Cost Reporting Period Ended -
See Appendix

CASE NO. 99-2365G

INDEX

ISSUE:

Were the Intermediary=s adjustments to physical therapy costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The HHS/AllCare 93-94, 96 Group (AProvider@) consists of two commonly owned home health agencies (AHHAs@) located in Denver, Colorado. The individual HHAs are Home Health Services of Metro Denver, Inc., and AllCare Home Health Services, Inc.

During the relevant cost reporting periods the Provider furnished home health services to Medicare beneficiaries including physical therapy (APT@) services. Blue Cross and Blue Shield of Iowa (AIntermediary@) concluded that the compensation paid by the Provider to its physical therapists was subject to Medicare=s reasonable cost/salary equivalency guidelines. Accordingly, the Intermediary applied the guidelines to the Provider=s cost reports which resulted in adjustments reducing the Provider=s allowable program costs and reimbursement.

The Provider properly appealed the Intermediary=s adjustments to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $109,000.

On February 15, 2001, the Provider and Intermediary entered a Stipulation of Facts. In part, the parties agree that the therapists who furnished services for the Provider were, in fact, employees of the Provider. In addition, the parties agree that the Provider=s therapists were compensated based upon a lump sum payment per visit and worked either full-time or on a per-diem basis.[1]
The Provider was represented by Elizabeth Zink Pearson, Esquire, of Pearson & Bernard PSC. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the salary equivalency guidelines used by the Intermediary were not intended to be applied to employee physical therapists.[2] Section 1861(v)(5)(A) of the Social Security Act (42 U.S.C. ' 1395x(v)(5)(A)) provides that where physical therapy services are furnished under arrangement with a provider of services or other organization, the amount allowable for Medicare reasonable cost reimbursement purposes shall not exceed the reasonable salary that would have been

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[1] See Appendix. See also Exhibit P-1.

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

paid for the same services (together with any additional costs that would have been incurred by the provider or other organization) under an employment relationship with the provider or other organization. The allowable cost (the salary equivalency) was to include other reasonable expenses incurred by the outside supplier in providing PT service, such as travel time, administrative costs, etc.

The Provider explains that implementing regulations at 42 C.F.R. ' 413.106, entitled Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements, limit payments for services rendered by specialists (such as physical therapists) who work for Medicare providers Aunder arrangements@ to the salary equivalency guidelines.

In pertinent part, 42 C.F.R. ' 413.106(a) states:

> [t]he 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. . . .

42 C.F.R. ' 413.106(a)(emphasis added).

The Provider notes that 42 C.F.R. ' 413.106(c)(1) states:

> Application (1) Under this provision, HCFA will establish criteria for use in determining the reasonable cost of physical, occupational, speech, and other therapy services and the services of other health specialists (other than physicians) furnished by individuals under arrangements with a provider of services, a clinic, a rehabilitation agency, or public health agency. It is recognized that providers have a wide variety of arrangements with such individuals. These individuals may be independent practitioners or employees of organizations furnishing various health care specialists. This provision does not require change in the substance of these arrangements.

42 C.F.R. ' 413.106(c)(1)(emphasis added).

The Provider also notes that Medicare=s Provider Reimbursement Manual, Part I (AHCFA Pub. 15-1@) states in several places that Aunder arrangements@ refers only to suppliers. For example, the main principle of HCFA Pub. 15-1 ' 1400, entitled Reasonable Costs of Therapy and Other Services Furnished by Outside Suppliers, states:

> [t]he reasonable cost of the services of physical, occupational, speech, and other therapists, or services of other health-related specialists (except physicians), performed by outside suppliers for a provider of services, a clinic, a rehabilitation agency, or a public health agency is limited to: (1) amounts equivalent to the salary and other costs that would have been incurred by the provider if the services had been performed in an employment relationship, plus (2) an allowance to compensate for other costs an individual not working as an employee might incur in furnishing services under arrangements.

HCFA Pub. 15-1 ' 1400.

Moreover, at HCFA Pub. 15-1 ' 1403, the manual explicitly states: A[t]he guidelines apply only to the costs of services performed by outside suppliers, not the salaries of providers= employees.@Id.

The Provider contends that the Board has consistently ruled for over 10 years that the guidelines used by the Intermediary do not apply to employee therapists. The Provider cites, for example, Alma Nelson Manor of Rockford, Illinois v. Aetna Life Insurance Co, PRRB Dec. No. 90-D15, February 26, 1990, Medicare & Medicaid Guide (CCH) & 38,429, decl=d rev., HCFA Admin., March 28, 1990, where the Board held that HCFA Pub. 15-1 ' 1403 was intended to apply only to situations involving outside suppliers such as contracted therapists, and not to the salaries of providers' employees. Similarly, the Provider cites Summit Nursing Home, Inc. of Freehold, New Jersey v. The Prudential Life Insurance Company of America, PRRB Dec. No. 88-D29, September 1, 1988, Medicare & Medicaid Guide (CCH) &37,408, decl=d rev., HCFA Admin., October, 6, 1988, where the Board again found that the guidelines apply only to the costs of services performed by outside suppliers and not to the salaries of provider employees.

The Provider contends that these prior Board decisions have been followed by more current Board findings as well as court rulings involving physical therapists employed by agencies and compensated on a per-visit basis. The Provider cites In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th. Cir. 1999)(AIn Home Health@); High Country Home Health, Inc. v. Shalala, 97-CV-1036-J (D.Wy. 1999), and All-Care Health Services v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D63, July 14, 2000, Medicare and Medicaid Guide (CCH) & 80,509, rev=d. HCFA Admin., September 9, 2000, Medicare and Medicaid Guide (CCH) & 80,621 (AAll-Care@).[3] According to

[3] Exhibits P-5, P-6, and P-7.

the Provider, the Eighth Circuit Court of Appeals, in affirming the Board=s decision, states:

> [t]he 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 Aunder arrangement@ and those provided by a person in an Aemployment relationship@ with a provider. The Guidelines apply to a person Aunder an arrangement.@ The final notice in the Federal Register indicates that a person Aunder 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.

In Home Health, supra at 1046.

Also regarding this matter, the Provider explains that on August 22, 1994, the Director of the Centers for Medicare and Medicaid Services= (ACMS@), formerly the Health Care Financing Administration (AHCFA@), Office of Payment Policy wrote a letter explaining that intermediaries must apply the guidelines to employed therapists that are paid on a per visit basis. In response, the Provider argues that CMS violated a Medicare statute and the Administrative Procedure Act by adopting a new rule without providing notice to the public and allowing for comment. The Provider asserts that 42 U.S. C. ' 1395hh provides that no rule, requirement, or other statement of policy that establishes or changes a substantive legal standard governing the scope of payment for services shall take effect unless it is promulgated by the Secretary of Health and Human Services (ASecretary@) after advance notice and opportunity for comment. The Administrative Procedure Act contains similar requirements. 5 U.S.C. ' 533. Accardi v. Shauahnessy, 347 U.S. 260 (1954); Red School House, Inc. v. Office of Economic Opportunity, 386 F. Supp. 1177 (D.Minn. 1974).

The Provider contends that regulations at 42 C.F.R ' 413.9 require intermediaries to reimburse providers for their reasonable costs of furnishing services to Medicare beneficiaries unless those costs are found to be substantially out-of-line with costs incurred by similar agencies.
Respectively, the Provider contends that the Intermediary has failed to show that the compensation it paid to its physical therapists is substantially out-of-line with the compensation paid by other similar agencies.[4] Rather, the Provider argues that the Intermediary adjusted its costs by taking a completely inapplicable reference point, the guidelines, and blindly applying them to its employee physical therapists= compensation. The Provider further asserts that while the Intermediary has failed to present any proof that its PT costs were Asubstantially out-of-line,@ a review of 1996 direct PT costs shows

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[4] Provider=s Final Supplemental Position Paper at 12.

that its PT cost per visit is in the mid-range of all other providers.[5]

The Provider notes that in prior cases the Intermediary argued that the guidelines should be deemed a Abenchmark@ for measuring reasonableness under Medicare=s prudent buyer concept. The Provider asserts, however, that this argument is factually in error, and contradictory to clear legal standards. See All-Care, supra.

The Provider also contends that the Intermediary applied the salary equivalency guidelines to its PT costs retroactively, which is unlawful.[6] The Provider explains that the Intermediary first applied the guidelines in 1995, and cites Health Insurance Association of America, Inc. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994), reversing the district court=s summary judgement in favor of the Secretary and holding that the Secretary could not recover payments previously made on the basis of interpretive rules which did not exist when the transactions at issue were conducted. See also Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988) (affirming district court=s summary judgement that the Secretary could not retroactively apply a salary index for hospital employees) and Minnesota Hospital Association v. Bowen, 703 F.Supp. 780 (D. Minn. 1988) (rule governing method of calculating Medicare reimbursement could not be applied retroactively).

The Provider contends that the Intermediary=s retroactive application of the guidelines also violates 42 U.S.C. ' 1395gg(c), which provides in part:

> [t]here shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b) (4), if such adjustment (or recovery) would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

42 U.S.C. ' 1395gg(c)(emphasis added).

The Provider cites Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger 517 F.2d 329 (5th. Cir. 1975) finding that: Arecoupment cannot be had from the provider where it was without fault,@ and asserts that it was without fault because its employment of physical therapists prior to March 31, 1995, was made with reliance upon 19 years of CMS reimbursement procedures.

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[5] Exhibit P-4.

[6] Provider=s Final Supplemental Position Paper at 14.

Finally, the Provider contends that it is unlawful for the Intermediary to apply the guidelines to its PT costs because they have not been updated as required by duly promulgated regulations.[7] Specifically, the Provider asserts that CMS is obligated to set the guidelines according to 42 C.F.R. ' 413.106(b)(1), which states:

> [t]he hourly salary rate based on the 75th percentile of salary ranges paid by providers in the geographical area, by type of therapy, to therapists working full-time in an employment relationship.

42 C.F.R. ' 413.106(b)(1).

Respectively, the Provider explains that CMS has not analyzed therapist salary ranges since 1982. CMS=s only revision of the guidelines since that time has been to apply a fixed monthly percentage increase of 0.6 percent per month. That rate has fallen far behind the salaries which the market actually requires providers to pay employee physical therapists. PT salary ranges have increased by more than 200 percent since 1982 while the guidelines have only increased by 100 percent.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustments applying salary equivalency guidelines to the Provider=s employee physical therapists are proper. The Intermediary explains that there is no dispute that the subject physical therapists were reimbursed on a per-visit basis, and pursuant to HCFA Pub. 15-1 '1403, such employee relationships are clearly subject to the guidelines. In part, the manual states:[8]

> [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.

HCFA Pub. 15-1 ' 1403.

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[7] Provider=s Final Supplemental Position Paper 15.

[8] Intermediary Position Paper at 9.

The Intermediary explains that there are several situations in which the compensation of salaried physical therapists are subject to the limitation of HCFA Pub. 15-1 ' 1403. The manual further states:

> [h]owever, 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.

HCFA Pub. 15-1 ' 1403.

The Intermediary asserts that CMS realized that certain salaried employment relationships would effectively circumvent the guidelines and, therefore, provided for these precise circumstances.

The Intermediary contends that its position is supported by the CMS Administrator=s reversal of the Board in High Country Home Health Care v. Blue Cross and Blue Shield Association et. al , PRRB Dec. No. 97-D35, March 19, 1997, Medicare and Medicaid Guide (CCH) & 45,130, rev=d., CMS Administrator, May 20, 1997, Medicare and Medicaid Guide (CCH) & 45,543, (AHigh Country@) and In Home Health v. Blue Cross and Blue Shield Association et. al. PRRB Dec. No. 96-D16, February 27, 1996, Medicare and Medicaid Guide (CCH) & 44,065, rev=d., CMS Administrator, April 29, 1996, Medicare and Medicaid Guide (CCH) & 44,595, finding that the intermediary properly applied the salary equivalency guidelines to the Aper-visit@ compensated physical therapists.[9] The Intermediary asserts that although the above Administrator decisions were overturned by the U.S. District Court of Appeals in Minnesota, the district court findings do not apply to this case as the Provider is located in Colorado.

The Intermediary also contends that its adjustments were made in accordance with 42 C.F.R ' 413.9 - Cost Related to Patient Care, 42 C.F.R ' 413.106 - Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements, and HCFA Pub. 15-1 ' 2103- Prudent Buyer.

Specifically, the Intermediary explains that 42 C.F.R. ' 413.106(c)(5) states: A[u]ntil a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service.@ Manual instructions at HCFA Pub. 15-1 ' 1403 state: A[u]ntil specific guidelines are issued for the evaluation of the reasonable costs of other services furnished by outside suppliers, such costs continue to be evaluated under the Medicare programs requirement that only reasonable costs be reimbursed.@ Respectively, the Intermediary argues that these rules are, in effect, guidelines for applying Medicare=s prudent buyer principle. The

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[9] Intermediary Position Paper at 10.

Intermediary adds that this position is supported by CMS,[10] and is offered as support that the audit adjustments in dispute are in accordance with 42 C.F.R ' 413.9(c)(2), which states,

> [t]he costs of providers= services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution=s costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

42 C.F.R ' 413.9(c)(2)(emphasis added).[11]

The Intermediary rejects the Provider=s argument that the salary equivalency guidelines do not apply to physical therapists who are employees rather than contractors.[12] As discussed above, the Intermediary does not dispute that the Provider=s physical therapists were employees. However, as noted in HCFA Pub. 15-1 ' 1403: A[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.@ (Emphasis added.)

The Intermediary also rejects the Provider=s argument that CMS=s letter dated August 22, 1994, which explained that intermediaries must apply the guidelines to employee physical therapists reimbursed on a per-visit basis was a Anew rule@ illegally adopted and applied.[13] The Intermediary asserts that Medicare policy requiring the application of the guidelines to fee-for-service therapists does not involve the application of a substantive rule, nor is the policy new. Notably, the rulemaking requirements of the Administrative Procedure Act are not applicable to interpretive rules, general statements of policy, or rules of agency organization, procedure or practice. In this case, the policy of applying the guidelines to fee-for-service arrangements has been in HCFA Pub. 15-1 ' 1403 since 1977.

The Intermediary also rejects the Provider=s argument that the guidelines should not be applied to its

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10 See Exhibit I-7

11 See also HCFA Pub. 15-1 ' 2103.

12 Intermediary Position Paper at 7.

13 Id.

physical therapists= compensation because they have not been updated as required by regulation.[14] The Intermediary explains that pursuant to HCFA Pub. 15-1 ' 1499, Exhibit A-8, Athe published guideline amount will be adjusted upward by a factor equal to .6 percent for each lapsed month between October 1,1982 and the beginning month of the provider=s cost reporting period.@

Finally, the Intermediary rejects the argument that it has failed to prove that the Provider=s physical therapists= costs are Asubstantially out of line@ with the costs paid by other home health agencies. The Intermediary asserts that the fact the Provider=s PT costs exceed the guidelines is evidence that the costs are not reasonable or are out of line. Moreover, however, according to the 1994-1995 Home Care Salary & Benefits Report, the average rate for physical therapists paid on a per-visit basis in Denver, Colorado ranged from $37.80 to $40.00 per visit.[15] This further supports the Intermediary=s position considering that the Provider=s rates per visit ranged as follows:

Fiscal Year End	Average PT Cost/Visit
9/30/93	$60.87
5/9/94	$63.99
5/31/94	$57.11
5/31/96	$59.87

In conclusion, the Intermediary asserts that the prudent and cost conscious buyer refuses to pay more than the going price for an item or service and seeks to economize by minimizing cost. The amount paid by the Provider for PT services was not prudent to the extent of about $97,763 for the cost reporting periods at issue.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

' 1395x(v)(5)(A)	-	Reasonable Cost [Therapy Services Furnished Under Arrangement]
' 1395gg(c)	-	Overpayment on Behalf of

[14] Intermediary Position Paper at 8.

[15] Exhibit I-10.

Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals

' 1395hh - Regulations

2. Law - 5 U.S.C.:

' 533 - Notice and Comment Procedures.

3. Regulations - 42 C.F.R.:

" 1835-.1841 - Board Jurisdiction

' 413.9 et seq. - Cost Related to Patient Care

' 413.106 et seq. - Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements

4. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

' 1400 - Reasonable Cost of Physical and Other Therapy Services Furnished by Outside Suppliers-Principle

' 1403 - Reasonable Cost of Physical and Other Therapy Services Furnished by Outside Suppliers-Guideline Application

' 1499 (Exhibit A-8) - Exhibits-Schedule of Guidelines for Physical Therapy Services Furnished by Outside Suppliers On or After October 1, 1982.

' 2103 - Prudent Buyer

5. Case Law:

Alma Nelson Manor of Rockford, Illinois v. Aetna Life Insurance Co, PRRB Dec. No. 90-D15, February 26, 1990, Medicare & Medicaid Guide (CCH) & 38,429, decl=d rev. HCFA Admin., March 28, 1990.

Summit Nursing Home, Inc. of Freehold, New Jersey v. The Prudential Life Insurance Company of America, PRRB Dec. No. 88-D29, September 1, 1988, Medicare & Medicaid Guide (CCH) &37,408, decl=d rev., HCFA Admin., October, 6, 1988.

In Home Health v. Blue Cross and Blue Shield Association et. al. PRRB Dec. No.96-D16, February 27, 1996, Medicare and Medicaid Guide (CCH) & 44,065, rev=d., CMS Administrator, April 29, 1996, Medicare and Medicaid Guide (CCH) & 44,595.

In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th. Cir. 1999).

High Country Home Health Care v. Blue Cross and Blue Shield Association et. al , PRRB Dec. No. 97-D35, March 19, 1997, Medicare and Medicaid Guide (CCH) & 45,130, rev=d., CMS Administrator, May 20, 1997, Medicare and Medicaid Guide (CCH) & 45,543.

High Country Home Health, Inc. v. Shalala, 97-CV-1036-J (D.Wy. 1999).

All-Care Health Services v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D63, July 14, 2000, Medicare and Medicaid Guide (CCH) & 80,509, rev=d., HCFA Admin., September 9, 2000, Medicare and Medicaid Guide (CCH) & 80,621.

Accardi v. Shauahnessy, 347 U.S. 260 (1954).

Red School House, Inc. v. Office of Economic Opportunity, 386 F. Supp. 1177 (D.Minn. 1974).

Health Insurance Association of America, Inc., v. Shalala, 23 F.3d 412 (D.C. Cir. 1994). Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

Minnesota Hospital Association v. Bowen, 703 F.Supp. 780 (D. Minn. 1988).

Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger 517 F.2d 329 (5th. Cir. 1975).

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 which it paid a lump sum for each patient visit they performed. The Intermediary applied the salary equivalency guidelines contained in HCFA Pub. 15-1 ' 1400 to the therapists= compensation reducing the Provider=s allowable program costs and reimbursement. The Intermediary argues 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.

HCFA Pub. 15-1 ' 1403.

Notwithstanding, the Intermediary argues that its application of the guidelines to the Provider=s physical therapy costs is also appropriate pursuant to Medicare=s prudent buyer principles found at HCFA Pub. 15-1 ' 2103.

The Board finds, however, that the Intermediary=s application of the salary equivalency guidelines to the Provider=s costs is 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 services performed by employees of a provider from services that are performed Aunder an arrangement,@ and indicates that the services performed by a physical therapist in an employment relationship with a provider are different from the services performed Aunder an arrangement.@ The guidelines, therefore, do not apply to employee physical therapists even though they are paid on a fee-for-service basis.

As noted in prior decisions, see e.g., High Country, the Board finds that 42 U.S.C. ' 1395x(v)(5)(A), and 42 C.F.R. ' 413.106, the implementing regulation, provide no basis for the application of the guidelines to the subject employee physical therapists. Both the legislative and regulatory history of the guidelines indicate that their purpose is to curtail and prevent perceived abuse in the practice of outside physical therapy contractors. The Board notes that the term Aunder arrangement@ is commonly

referred to and used interchangeably with the term Aoutside contractor.@[16]

Finally, with respect to this matter, the Board finds that recent court decisions support its position. The Board cites In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th. Cir. 1999) and High Country Home Health, Inc. v. Shalala, 97-CV-1036-J (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 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 Aunder an arrangement@ with a provider. The second part of the sentence explains that the reasonable cost of compensation for the persons Aunder an arrangement@ is calculated by reference to the salary which would reasonably have been paid to the person if that person had been in an Aemployment 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 Aunder an arrangement@ and those provided by a person in an Aemployment relationship.@ It is clear from the language that a physical therapist who is Aunder an arrangement@ is different from a person in an Aemployment relationship@ with the provider. The Guidelines apply to a person Aunder an arrangement.@ The final notice in the Federal Register indicates that a person Aunder an arrangement@ is an outside contractor. The Secretary=s attempt to now further limit the term Aemployment 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

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[16] The Board also notes that 42 C.F.R. ' 413.106 was changed in 1998 to include the application of the guidelines to employees who are paid on a fee-for-service basis. However, this change is not applicable to the subject cost reporting periods.

> themselves subject to a reasonableness requirement. See 42 U.S.C. ' 1395x(v)(l). . .[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.]

Id. (Emphasis added.)

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 Asubstantially out of line@ by a comparison of those costs to those incurred by other similarly situated providers. 42 C.F.R. 413.9. The Board acknowledges that the Intermediary compared data from the Home Care Salary & Benefits Report (1994-1995) (AHome Care Report@) to the Provider=s physical therapist costs in an effort to support its application of the guidelines under Medicare=s prudent buyer concept. However, the Board is not convinced that this comparison produces valid results.

In particular, the Board finds that the Intermediary compared APer Visit Rates@ obtained from the Home Care Report, which do not include employee fringe benefits, to the Provider=s physical therapist costs which seemly include employee fringe benefits as well as transportation and other expenses. As noted in the Home Care Report, APer Visit Rates@ are amounts Apaid@ to field personnel, while AFringe Benefits@ are shown separately in another section (Section XII) of the report. Exhibit I-10 at 14. On the other hand, the Provider=s costs reflect Atotal compensation claimed. . . for its employed physical therapists. . .@ from Worksheet A of its cost reports. Exhibit P-1 at 3, and Exhibit P-4. Moreover, the data contained in the Home Care Report was obtained from a survey conducted in 1994. Yet, the Intermediary compared this data to the Provider=s 1996 costs having not updated it for that period.

In all, the Board finds that the Intermediary did not develop its prudent buyer analysis sufficiently to support a reduction in the Provider=s costs. The Intermediary should have obtained like data from HHAs in the Denver area that are similar to the Provider in terms of size, scope of services, and utilization, to determine whether or not adjustments were warranted.

DECISION AND ORDER:

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

Board Members Participating:

Irvin W. Kues

Henry C. Wessman, Esq.
Stanley J. Sokolove

Date of Decision: September 14, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman