CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	
HCT 94-95 Physical Therapy	
AHSEA Exception Group	**Claim for: Cost Reimbursement Determination for Cost Reporting Periods Ending 12/31/94 and 12/31/95**
Provider	
vs.	
Blue Cross Blue Shield	**Review of:**
Association/ Mutual of Omaha	**PRRB Dec. No. 2006-D21 Dated: May 25, 2006**
Intermediary	

This case is before the Administrator, Centers for Medicare and Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act). Comments were received from CMS' Centers for Medicare Management (CMM) requesting reversal of the Board's decision. The parties were notified of the Administrator's intent to review the Board's decision. Comments were received from the Provider requesting that the Board's decision be affirmed. Comments were also received from the Intermediary requesting reversal of the Board's decision. Accordingly, this decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary properly denied the Providers' requests for an exception to the Medicare allowable hourly salary equivalency amount (AHSEA or "guidelines") for physical therapy.

The Board reversed the Intermediary's adjustments, stating that the controlling regulation at 42 C.F.R. §413.106(f) does not place any time constraints on submission of exception requests. The Board rejected the argument that the requests of the Providers should be denied as they were submitted untimely. The Board also found that the Providers met the exception criteria of the regulation at

§413.106(f)(2), as they had demonstrated that the cost for therapy services established by the guidelines are inappropriate to the providers because of some unique circumstance or special labor market conditions in the area. The recruitment efforts were nearly identical for each of the Providers, the differences being the number of cold calls placed or interviews conducted by each Provider. The Board stated that, although the Providers claimed the advertisements were placed in many local newspapers across the region, only one copy of one advertisement was submitted. The document entitled "Health Care Centers of Texas Physical Therapy Advertising Efforts in 1995" identified heavy recruiting from January through March of 1995, but only two recruiting efforts from April through December.

The Board wrote that, although the Providers claimed cold calls were placed to local therapists, and that numerous telephone calls were conducted to companies, no records were maintained of individuals or companies so contacted. Although advertisement and recruiting efforts of the Providers were not substantiated in the record, the Board found that genuine and on-going efforts were conducted, and those efforts eventually resulted in positive results. Of the ten facilities included in this appeal, eight began the fiscal year utilizing contracted therapists at rates exceeding the AHSEA, and of those eight, five facilities found staff therapists, or contract therapists at the AHSEA, and the remaining three hired staff therapists within six months of the Fiscal Years end. Both facilities that commenced utilizing contracted therapists above the AHSEA during the cost reporting years were able to hire a staff therapist, or a contracted therapist, at the AHSEA limits within four months.

The Board stated that it appeared that the utilization of contracted therapists at rates exceeding the AHSEA was temporary, as all of the Providers were eventually able to furnish services within the guidelines. With regard to the arguments relating to the Intermediary's survey, the assertion that approximately 75 percent of the other facilities in the region did not exceed the AHSEA limits does not justify a conclusion that there was a pool of labor available to furnish services for each of these Providers. The distance between many of the Providers and the large population areas may have been too far to have physical therapists immediately on demand.

SUMMARY OF COMMENTS

The Providers requested that the Administrator affirm the Board's decision, arguing that it is entitled to an exception to the AHSEA based on a showing of unique circumstances or special labor market conditions. The Providers do not contend that its rural location in sparsely populated areas alone justify a finding of "unique circumstances or special labor market conditions". The fact that other providers

situated in rural areas did not seek an exception to the AHSEA, including the vast majority of 58 facilities operated by the prior owner, does not compel the conclusion that more physical therapists were available to furnish services within the AHSEA amounts. The Providers stated that it demonstrated that the distances and transportation time required to deliver physical therapy services to patients, due to the location of the various facilities relative to the nearest population centers where physical therapists might be obtained, in combination with the transitional displacement inherit in changes of ownership, temporarily subjected them to special labor market conditions. For these ten Providers, extensive efforts to procure physical therapy services within the AHSEA limits for the entire cost reporting periods were unavailable. Of these ten Providers, seven Providers were successful in finding replacement physical therapy venders within the Medicare AHSEA guidelines for some or most the fiscal years in issue as was noted by the analysis of the Board. Only three of the ten Providers were forced to pay compensation over the salary equivalency rate throughout the entire cost reporting periods.

The Providers stated that this data contradicts the Intermediary's allegation that it made a business decision to limit its cost exposure by contracting for therapy services. The disputed reimbursement represents funds that were paid by the Providers as a necessity to obtain professional services. The Providers also argued that the Intermediary's position assumed a static labor market with an adequate supply of physical therapists to meet therapy needs of beneficiaries, strategically located in proximity to all providers in the state. In order to maintain consistent patient care, in a dynamic and changing labor market, these Providers were forced to temporarily utilize therapists at rates exceeding AHSEA. The Providers stated that the historic ability of the previous owner, or other providers, to stay within the limits and the subsequent ability of these Providers to obtain physical therapy services at or near the AHSEA rates does not disprove unique circumstances or special labor market conditions.

The Providers objected to the Intermediary making mention of the Board's statement that the “representation of advertisement and recruitment efforts were not substantial in the record.” The Providers claimed to have demonstrated recruitment efforts to employ therapy services within the limits by conducting cold calls to licensed therapists, contacting over 75 therapy companies, mailing recruitment letters to members of the Texas Physical Therapy Association (Association) and participating in professional conferences to recruit physical therapists for needed locations and facilities. The Intermediary's criticism that the Providers' recruitment efforts were “not substantial” and “limited” misrepresents the record.

The Provider argued that the continued recruitment in October of 1995, substantiated the on-going efforts of the Providers to obtain therapy services within

the AHSEA limits for the remaining three Providers who paid above the AHSEA rates at the time. Moreover, many of the recruitment efforts did not lend themselves to appear "substantially" in the record: cold calls to therapists, telephone calls to therapists and interviews, did not create documentation. The date by which the various Providers were able to procure therapy services at or near the AHSEA limits demonstrate that recruitment efforts were on-going.

The Providers also stated that the Board properly determined that it met the criteria of unique circumstances or labor market conditions for an exception under 42 CFR 413.106(f)(2) for the cost reporting periods at issue and disregarding the allegation of the Intermediary that the exception request were submitted untimely. The Providers' contend that the letters, dated March 29, 1996, were separately mailed to the Intermediary and requested an exception to the hourly and travel limits applied to physical therapy services by outside suppliers. The Intermediary now contended that receipt of those submissions was never substantiated, but substantial discovery followed, as the appeal developed over the course of 10 years. At no time over the course of those 10 years, did the Intermediary cite its timeliness objection, instead, it proceeded with the appeals process, and requested evidence from the Providers to prove it met the criteria to be granted an exception.

The Provider argued that the Intermediary's handling of the appeal adds further weight to the presumption that the exception was properly and timely requested. The timeliness of an exception has no bearing on the material fact that the Providers, having no alternative, paid rates for necessary physical therapy services in excess of AHSEA for a period of time. To dismiss this appeal because it cannot be proven that the exception was requested within ninety days of the end of the cost report year would elevate form over substance, in abrogation of the policy and principles under girding the Medicare program.

The Intermediary requested reversal of the Board's decision, contending that the Providers are not entitled to an exception to physical therapy AHSEA, as they lack "unique circumstances" or "special labor market conditions" as set forth in the regulation at §413.106(f). Unique circumstances would include things beyond the control of the Providers, which is not present. The special labor market criteria also was not met and was not proven by the Providers.

The Intermediary referred to the Board's statement in support of its contention that the Providers' documentation for the requests was limited, stating that only one copy of one advertisement was submitted as support. In addition, the document entitled 'Health Care Centers of Texas Physical Therapy Advertising Efforts in 1995' identifies heavy recruiting … [from January through March of]] 1995, but only 2 recruiting efforts from April through December." The Board also noted "… [T]he Providers' representation of advertisement and recruitment efforts was not substantial in the record…." The Intermediary stated that, even though the record

was not substantial, the Board decided that the Providers deserved an exception. Since the evidence was not substantiated, the Intermediary contends that the Providers have not demonstrated, with required substantial evidence, that it was entitled to an exception.

The Intermediary contended that the circumstances were not unique but more the result of a business decision, (which is under the Providers' control) to limit its cost exposure by contracting for therapy services. By paying more for the actual hours used for physical therapy, rather than hiring salaried employees under its immediate control, the Providers could avoid excess costs should the physical therapy services not be fully utilized. The Providers could have hired salaried employees when the change of ownership occurred, but made a business decision to contract for these services. The Providers argued that: "The Intermediary overlooks the reality that contracts expire, and changes in ownership typically prompt employees to explore alternative options" as the basis for its unique situation to incur costs above AHSEA. The Intermediary argued that changes of ownership and resulting impacts are frequent within the provider community and do not give rise to unique circumstances..

However, the Intermediary referred to its survey, stating that most of the high exceptions were noted in the larger metropolitan areas and not in the rural areas. The Providers in this group are located in rural areas. The Intermediary stated that it contacted the audit manager for another intermediary in the area, inquiring whether any facilities had previously requested exceptions to the limits, who indicated that none of the skilled nursing facilities had been granted exceptions to the AHSEA, nor had there been any requests for that fact. The going rate in the area did not justify an exception for special labor market conditions. The Intermediary also pointed out that the Providers stated that the vast majority of the commonly owned 58 facilities, though all located in rural areas, are not joined in this appeal seeking the exception to its physical therapy AHSEA rate. The majority of the facilities were able to employ or contract physical therapy services within or close to the Medicare AHSEA. The Intermediary stated that this statement in combination with the fact that other providers in the area were able to seek and utilize services at or below AHSEA, together with unsubstantiated evidence, indicate that the Providers have not demonstrated that it met the unique circumstances or special labor market conditions.

The Intermediary pointed out a great deal of controversy concerns the submission of the exception requests by the Providers to its former intermediary. The Providers contended that the exception request was made as part of its cost report submission. In most instances, the cost report submission was required within 150 days of the cost reporting period end, and not the 90 day period as set forth in the Provider Reimbursement Manual (PRM) §1414.2. This provision was not updated from 90 days to 150 days until CMS Transmittal No. 403, dated June 1998, thus,

the old CMS Transmittal No. 268, dated September 1982, was in effect. The Providers claimed that they, respectively filed the exception request for the December 31, 1994, and December 31, 1995, cost reports, on April 28, 1995, and May 31, 1996. The 90 day time filing limitation for physical therapy exception requests would be respectively March 31, 1995 and March 31, 1996. The Providers' Position Paper reveals a separate unsigned exception request (dated March 29, 1996) to its former intermediary. The Board's decision made an erroneous finding in stating that the timeliness requirement was without merit. The controlling policy to which the Board should have given "great weight" is set forth in the PRM at §1414.2.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Since the inception of the Medicare program in 1966, reimbursement of providers has been governed by, inter alia, §1861(v)(1)(A) of the Act. Section 1861(v)(1)(A) of the Act provides:

> Reasonable costs shall be the costs actually incurred, excluding, there from, any part of incurred costs found to be unnecessary in the efficient delivery of needed health care….

In addition, the Secretary has been granted authority over §1861(v)(1)(A) of the Act to establish:

> Limits on direct and indirect overall incurred costs, or incurred costs of specific items, or services, or groups of items or services to be recognized as reasonable, based on estimates of the costs, necessary in the efficient delivery of needed health services to individuals covered by the health insurance program established under this title….

The Secretary has promulgated regulations at 42 C.F.R. §413.9, which provides that all payments to providers must be based on reasonable cost of services covered under Title XVIII of the Act and related to the care of beneficiaries. In addition, the Providers must meet the documentation requirements of both the Act and the regulations in order to demonstrate entitlement to reimbursement.[1]

[1] Section 1851 of the Act [42 USC 1395g]; 42 CFR 413.20; 42 CFR 413.24.

Under §1815 of the Act, which provides for payment to providers of services, no Medicare payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Consistent with the statute, the regulations governing cost reimbursement, as well as claims under the inpatient prospective payment system (IPPS) require that providers maintain verifiable documentation to justify their requests for payment under Medicare. 42 CFR 413.24 Further, an underlying principle set forth in the Act is that Medicare shall not pay for costs incurred by non- Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs under Section 1861(v)(1)(A) of the Act. This principle is also reflected at 42 C.F.R. §413.9, which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. If the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Generally, while Medicare will pay the reasonable costs for physical therapy services, such costs when supplied under arrangement (including on a per visit basis), may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or had such services been performed by such person in an employment relationship, plus the costs of other reasonable expenses incurred by such person in providing service under such an arrangement. The regulation at 42 CFR §413.106 establishes guidelines governing the amounts to be paid for physical services furnished by outside suppliers. The regulation at 42 CFR §413.106(f) also allows for exceptions to the guidelines under certain circumstances. In particular, paragraph (f) provides that:

> (f) Exceptions. The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present …
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> ….
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> (2) Exception because of unique circumstances or special labor market conditions. An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services established by the guidelines amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

Section 1414.2 of the PRM sets out the criteria for granting an exception because of unique circumstances or special labor market conditions. The PRM explains that:

> [b]efore the exception may be granted, the provider must substantiate appropriate evidence to its intermediary to substantiate its claim the provider's request for an exception, together with substantiating documentation, must be submitted to the intermediary each year no later than 90 days after the close of its cost reporting period.

With respect to unique circumstances, the PRM explains that:

> To establish an exception for unique circumstances, the provider must submit evidence to establish that it has some unique method of delivering therapy or other services, which effects the costs different from the other providers in the area.

With respect to special labor market conditions, the PRM states that:

> In order to substantiate special labor market conditions, the provider must submit evidence enabling the intermediary to establish that the going rate in the area for this particular type of service is higher than the guideline limit and that such services are unavailable at the guideline amounts….It is the duty of the provider to prove to the satisfaction of the intermediary that it has reasonably exhausted possible sources of this services without success. As a minimum, the provider must submit documentation showing the salary or wage rates it pays its therapists and other health care specialists. The provider must also submit evidence to establish that it has advertised on several occasions in a newspaper having widespread circulation in the area and that it has contacted employment agencies in the area, if available. The exception will be effective no earlier than the date, as documented in the evidence of record, that [a] provider initiated a concerted effort to secure the therapy services from other sources.

The PRM also explains that:

> It is the responsibility of the intermediary to determine the rates that other providers in the area generally have to pay therapist or other health care specialists…. Once this information is collected, the intermediary will then determine whether or not other providers in the area, in comparison to the provider requesting the exception, generally have to pay therapists or other health care specialists higher rates than the guidelines. For this exception "area" is defined as that region or regions which constitute the normal labor market for the provider. Therefore the area should not be confined merely to the locality in which the provider is located, but should also include those

> populous areas from which the provider would reasonably be expected to secure professional services….
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> ….
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> The key to an exception is not the rate requested for performing the particular type of service being evaluated, but the going rate for therapists … performing these services particularly salaried individuals, who are working in the area. If other providers in the area generally are able to obtain those services at rates that do not exceed the guidelines, an exception would not be appropriate.

Furthermore, the PRM shows that if a provider meets the criteria for an exception for special labor market conditions, the amount allowed is based on the going rate for salaried therapists in the area as opposed to the actual amount paid by the provider for the service. Hence, the determination of the going rate paid by providers not only affects whether a provider will receive an exception but also, if granted, how much of an exception amount that provider will receive above the AHSEA limits.

The record reflects that the group appeal involves ten Provider[2]s, which are located in rural Texas which were purchase in 1994. The Providers filed Medicare cost reports with the former intermediary which reviewed each cost report and issued the Notices of Program Reimbursement. This intermediary subsequently ceased operations as contractor, and the present Intermediary was selected as the replacement. The Providers' cost reporting periods at issue are the fiscal years ending December 31, 1994 and December 31, 1995.

The Providers claim that they timely requested exceptions to the physical therapy guidelines under 42 CFR §413.106(f)(2). The Intermediary claimed that the Providers' suggested that the exceptions were filed with the cost reports (April 28, 1995 for FY 1994 and May 31, 1996 for FY 1995). The Providers do not specifically rebut this allegation. However, the Providers submitted an unsigned letter requesting exceptions, dated March 29, 1996. While the letter indicated that it was sent certified mail, the Providers did not include any certified mail related documentation of receipt. The Administrator finds that the record is unclear when

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[2] The Providers, include: Andrews Health Care Center, Borger Health Care Center, Childress Health Care Center, Gibson Health Care Center, Gilmore Health Care Center, Olney Health Care Center, Nederland Health Care Center, Red River Health Care Center, Throckmorton HealthCare Center and Snyder Health Care Center. See Intermediary Exhibit 1, Schedule of Providers in Group Appeal dated April 20, 2001.

the Providers submitted their exception requests and that it is the Providers' burden to show timely submission within the 90 day period specified at §1414.2 of the PRM. Assuming the Providers filed their exceptions with the cost reports, they would have been untimely filed. In addition, assuming the Providers filed the exception requests on the date shown on the letter, the Administrator finds that the exception requests would have been late for the FYEs 1994 cost reports.

However, even assuming that the requests can be considered, the Administrator also finds that the Providers failed to demonstrate that they meet the criteria for an exception under 42 CFR §413.106 and the PRM at §1414.2. First, the Administrator finds that the Providers failed to demonstrate unique circumstances. To establish an exception for unique circumstances, the provider must submit evidence to establish that it has some unique method of delivering therapy or other services, which effects the costs different from the other providers in the area. The Providers failed to demonstrate that their higher costs were directly related to a unique method of delivery.

In addition, the Administrator determines that the advertising and recruitment efforts of the Providers were not supported with contemporaneous documentation demonstrating a genuine and ongoing attempt to recruit physical therapy suppliers which is necessary to meet the special labor market conditions criteria. The PRM at §1414.2 sets forth examples of minimal documentation that the Providers were required to furnish in order to substantiate their requests, including advertisements and contacts to agencies. The Administrator finds that the documentation put forth by the Providers was unverifiable. For the most part, the documentation for all of the Providers was the same.

While the record for each Provider varied, all were very similar. All the Providers had a photocopy of a single advertisement that had no indication of the publication in which it may have been generated or any date or dates of publication. The record, as to all the Providers, also had a very general listing of contractor companies who were purportedly contacted, but whether these companies, per the PRM, were actually contacted and by whom and the dates of the contacts could not be verified. The record also contained a document created after the fact indicating the efforts undertaken to advertise/recruit physical therapists. This showed the extent that the Providers efforts varied, but these statements made on behalf of each Provider had no documentation to support that these efforts were in fact made. There is also a document supplying a list of companies along with the allegation that they were contacted, that cold calls were made, the letters/ notices mailed to the Association and the interviews that may have been conducted. Again, the documents are either created after the fact, or do not indicate when they were created, or when contacts were made, and by whom they were made and, thus, are not verifiable. The Administrator concludes that the advertising and recruiting

efforts undertaken by the Providers, as demonstrated in the record, were unsubstantiated.

Based on the record, the Administrator finds that the Providers did not qualify for an exception to special labor market conditions. The PRM at §1414.2 states that an exception is not proper, for instance, where an individual refuses to provide services from other sources at the rate prescribed so long as it is possible for the provider to secure such services from other sources. The Administrator determines that the Providers failed to demonstrate they attempted to procure sources of physical therapy services from other sources at the proscribed AHSEA amounts and that their failure to do so was because of special labor market conditions.

In addition, although the Board disregarded the Intermediary's survey, the PRM specifies that if other providers in the area generally are able to obtain these services at rates that do not exceed the guidelines, an exception would not be appropriate. The Intermediary conducted a survey of 146 providers in the same geographic regions as the Providers (Intermediary Exhibit I-8) including 152 cost reports. Of those providers, 57 percent, or 81 providers, used outside suppliers. Of those 81 providers, only 26 providers, or 18 percent, exceeded the AHSEA limit. In addition, 12 of the 26 providers were in urban areas in contrast to the Providers' unsubstantiated theory that rural areas had higher physical therapy contractor costs. In addition, the record shows that the granting of exceptions was rare or nonexistence in these areas as the vast majority of providers in Texas were able to provide therapy services within the established AHSEA limits. In fact, the Providers were able to contract for such physical therapist for the most part before the end of the cost reporting periods. Consequently, the Administrator finds that the Providers were not able to establish that their higher costs associated with their physical therapy suppliers were related to special labor market conditions or unique circumstances and, thus, the Intermediary properly disallowed the exception requests.

DECISION

The Board's decision is reversed consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 7/27/06 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services