CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Potomac Home Health Care, Inc. **Provider** **vs.** **Blue Cross Blue Shield Association/ Association/ Cahaba Government Benefit Administrators** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: June 30, 1995, June 30, 1996 and June 30, 1999** **Review of:** **PRRB Dec. No. 2005-D70** **Dated: September 27, 2005**

This case is before the Administrator, Centers for Medicare & 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), as amended (42 USC 1395oo(f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMS' Center for Medicare Management (CMM) requesting that the Board's decision be reversed. Comments were also received from the Provider requesting affirmation of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue before the Administrator is whether the Intermediary's adjustment applying the Salary Equivalency Guidelines (Guidelines) or "physical therapy compensation guidelines" to fee-for-service employee compensation was proper.

The Board held the Intermediary improperly applied the Guidelines to the Provider's employed physical therapists who were paid on a fee-for-service basis. The Board found that the Intermediary improperly adjusted the Provider's cost report by applying the physical therapy guidelines for therapy services provided "under arrangement" by outside contractors to the wages paid to the Provider's employee

therapists. The Board cited the court in *In Home Health, Inc. v. Shalala*, 188F.3d 1043 (8th Cir. 1999) which stated "the Act clearly states that physical therapy services performed 'under arrangement' do not include services performed by a physical therapist in an employment relationship with the provider." The Board also explained that the salary equivalency guidelines should not be used in place of a prudent buyer analysis. However, the Intermediary used the guidelines and did not perform a prudent buyer analysis. The Board also found the Provider's argument that its costs were reasonable was persuasive.[1]

COMMENTS

CMM commented requesting that the Board's decision be reversed. CMM stated that the issue was similar to that found in a prior PRRB decision (PRRB Dec. No. 2003-D11) and submitted the same comments which requested reversal of that decision. CMM maintained that the statute distinguishes between services furnished "under arrangement" and those provided through a salaried "employee relationship," and therefore physical therapists who were not salaried but who were paid on a per-visit basis, were subject to the salary equivalency guidelines. CMM also noted that because the plain language of the statute is silent or ambiguous on the issue of whether it should be applied to employees compensated on a per-visit basis, the interpretation of CMS should be upheld as reasonable.

The Provider commented requesting the Administrator affirm the Board's decision. The Provider argued that for the periods prior to April 10, 1998, the Guidelines are not lawfully applicable to the compensation of employed physical therapists. The Provider maintained that the statute and regulation are confined to "under arrangement" services rather than services provided pursuant to employment relationships. Similarly, although the Provider Reimbursement Manual provisions purport to permit the application of the guidelines to employment relationships featuring compensation similar to "under arrangement" relationships, the preamble to the originally published salary equivalency guidelines limited their application to "services furnished under arrangement by an outside contractor. In addition, the Provider asserted that, although the Secretary claimed that an amendment to the regulation to have the guidelines apply to employment relationships was a clarification, this claim is belied by the fact that the effective date of the regulatory change was April 10, 1998, after the periods at issue in this case. The Provider also cited to several case decisions in support of its position.

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[1] The Administrator summarily affirms the Board's decision on Issue No. 2 regarding interest expenses.

DISCUSSION AND EVALUATION

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 its inception in 1966, Medicare's reimbursement of health care providers was governed by §1814(b)(1)[2] and §1861(v)(1)(A) of the Act. Section 1861(v)(1)(A) of the Act provides that:

> reasonable cost shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services….

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

> limits on the 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 insurance programs established under this title….

The Secretary has promulgated regulations at 42 CFR 413.9 which provide that all payments to providers of services must be based on reasonable costs of services covered under Title XVIII of the Act and related to the care of beneficiaries. In addition, the Provider must meet the documentation requirements of both the Act and the regulations in order to demonstrate entitlement to reimbursement.[3]

Finally, the regulations at 42 CFR 413.106(c)(5) states in part, "[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." *Id.* This regulation is implemented by §1403 of the Provider Reimbursement Manual (PRM), which reads in part, "[u]ntil specific guidelines are issued for the evaluation of the reasonable costs of other services furnished by outside suppliers, such costs will continue to be evaluated under the Medicare programs requirement that only reasonable costs be reimbursed." *Id.*

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[2] 42 USC 1395(b)(1).

[3] Section 1815 of the Act (42 USC 1395g); 42 CFR 413.20; 42 CFR 413.24.

A limitation on payments for the reasonable cost of physical therapy services under arrangement was established by §251(c) of the Social Security Amendments of 1972[4] and §17(a) of the Social Security Amendments of 1973.[5] These amendments added §1861(v)(5)(A) of the Act which provides that:

> Where physical therapy services [and other therapy services] … are furnished *under an arrangement* with a provider of services …, the amount included in any payment to such provider … as the reasonable cost of such services … *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 … incurred by such person, as the Secretary may in regulations determine to be appropriate. (Emphasis added.)

Section 1861(w)(1) of the Act provides that:

> the term 'arrangements' is limited to arrangements under which receipt of payment by the … home health agency … (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

The Secretary implemented §1861(v)(5)(A) through the promulgation of 42 CFR 413.106, which defines the Guidelines as reflective of the "amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider … had such services been performed by such person in an employment relationship." In turn, subsection (b) defines "prevailing salary" as:

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

Consequently, the Guidelines, as explained at 42 CFR 413.106(b)(6), are the amounts published by the Secretary reflecting the application of §413.106(b)(1) through (4) to an individual therapy service and a geographical area. Paragraph (c) of the regulation states that:

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[4] Pub. Law 92-603.

[5] Pub. Law 93-233.

Under this provision, HCFA will establish criteria for use in determining the reasonable costs of physical … therapy services … furnished by individuals under arrangements with a provider of services…. 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 a change in the substance of these arrangements.

The Secretary's interpretation of the reasonable cost provision of §1861(v)(1)(A), the provisions of §1861(v)(5)(A) and the regulation at 42 CFR 413.106 is set forth in §1403 of the PRM. First promulgated in 1977, §1403 of the PRM states, *inter alia*, that:

> The guidelines apply only to the costs of services performed by outside suppliers, not the *salaries* of provider's 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 relationship, 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.
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> In situations where compensation, at least in part, is based on a fee-for-services or on a percentage of income (or commissions), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter.

The Administrator disagrees with the Board's analysis of the case and the relevant law and policy. The Administrator finds that, after a review of the controlling law, legislative history of the Act, and relevant Medicare policy, the Intermediary properly applied the Guidelines to the Provider's physical therapy compensation. Contrary to the Board's finding that the employment relationship between the Provider and the physical therapists determined whether the Guidelines should be applied, the Administrator finds that the fee-for-service compensation of the Provider's therapists was the controlling factor in the application of the limits in this case.

Because the Board found that the Provider "employed" physical therapists, the Board asserted that the physical therapists were exempt from the physical therapy Guidelines. However, the Administrator notes that the Secretary is not bound by the Internal Revenue Service (IRS) provisions in determining Medicare reimbursement.

The Administrator notes that these physical therapists may be employees under the IRS code but where compensation, at least in part, is based on fee-for-service, these payments are treated as nonsalaried payments under §1403 of the PRM and nonemployment relationships for Medicare reimbursement purposes.

The specific salary arrangements in this case are not consistent with prudent practices associated with full time employment. In this situation, the payment arrangements for the physical therapists are similar to nonsalaried personnel. The employment payment schemes for physical therapy services appear to be outside of a standard employment arrangement with the Provider and thus create the same opportunities for abuses as more traditionally defined contractor relationships. Consequently, wages paid on a fee-for-service or commissioned basis are governed by the Guidelines for purposes of Medicare reimbursement. The Administrator finds that §1861(v)(1)(A) of the Act authorizes the Secretary to determine reasonable costs and to implement limits on costs. That the Secretary has chosen to apply the Guidelines to the cost of employee compensation on a fee-for-service basis is not inconsistent with that authority. The law is well established that §1861(v)(1)(A) of the Act gives the Secretary "broad discretion" to determine what are reasonable costs.[6] The Administrator finds that the application of the Guidelines under these facts is a reasonable exercise of that discretion.

Moreover, with respect to the Secretary's authority to apply the Guidelines under these circumstances under the authority granted pursuant to §1861(v)(5)(A) of the Act, the Administrator finds it significant that the plain language of §1861(v)(5)(A) of the Act does not limit the application of the Guidelines only to non-employees or outside contractors. As evident from the foregoing statutory language, the phrase "under an arrangement" is not defined in the Act by reference to a legal employment situation under the IRS code, but rather, is defined in broad terms as where receipt of

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[6] *See, e.g., Good Samaritan Hospital v. Shalala*, 508 U.S. 402, 411, 419 (1993); *Mt. Diablo County Hosp. v. Bowen*, 811 F.2d 38, 343 (7th Cir. 1987) (section 1861 (v)(1)(A) gives the Secretary wide latitude in prescribing regulations governing the process of determining reasonable costs). In *Good Samaritan*, the Supreme Court noted that section 1861(v)(1)(A) "explicitly delegates to the Secretary the authority to develop regulatory methods for the estimation of reasonable costs," 508 U.S. at 418, and likened this authority to the "exceptionally broad authority" that congress bestowed upon the Secretary in other areas of the Social Security Act. *Id.* Pursuant to this authority, the Secretary has promulgated regulations establishing cost limits, *see* 42 CFR 413.30, and has provided that the cost limits may be calculated on a "per admission, per discharge, per diem, *per visit*, or other basis,"*id.* At 413.30(a)(2) (emphasis added).

Medicare payment by a provider discharges the liability of the beneficiary to pay for such services. Although the language of §1861(v)(5)(A) clearly applies in situations where there is an outside contractor relationship, the plain language of the statute does not actually define "under arrangement" with those terms and, thus, does not specifically exclude employment situations.

In addition, both the language of the statute and the legislative history of the Act support the conclusion that Congress was concerned with limiting costs associated with fee-for-service arrangements such as those in this case. In drafting the language of §1861(v)(5)(A), Congress chose to refer to the form of compensation, "salary," rather than the form of the legal relationship between provider and therapist to establish the standard for determining the applicable limits. Thus, this limit is established based on salary compensation, i.e., a fixed compensation which is periodically paid to a person for regular work or service.

Moreover, the legislative history clearly reflects that Congress expected this limit (salary-based) would be applied to fee-for-service arrangements, as Congress was concerned about the cost implications of therapy provided under fee-for-service arrangements, as opposed to salary-based compensation.[7] Thus, rather than focusing on the exact nature of the legal relationship between the provider and the therapists, Congress focused on the form of compensation to the therapist, viewing fee-for-service arrangements as the most likely area for uncontrolled costs and potential abuse.

Consequently, the statutory language of §1861(v)(5)(A) and its legislative history all indicate that Congress did not contemplate all possible forms of fee-for-service arrangements and, thus, did not contemplate fee-for-service arrangements within the context of a formal employment relationship. However, it is equally evident that the purpose of enacting §1861(v)(5)(A) of the Act was to place limits on physical therapy fee-for-service compensation costs. Because of the ambiguity of the language at §1861(v)(5)(A), the Secretary's interpretation of the statute is entitled to

[7] S. Rep. No. 92-1230, 92nd Cong., 2nd. Sess. 52(1972) (provision will "limit reimbursement for physical and other therapist to a reasonable salary related basis rather than a fee-for-services basis."); H. Rep. No. 992-231. 92nd Cong. 1st Sess. 110 (1971) ("Committee bill includes … provisions for controlling program expenditures for therapy services … and for preventing abuse"); S. Rep. No. 93-533, 93rd Cong. 1st Sess. 68 (1973) ("the cost that would have been occurred if payment had been on a reasonable salary-related basis rather than on a fee-for-service").

considerable deference as long as it is reasonable.[8] The Administrator finds that the Secretary's interpretation of the Act, to consider the phrase "under arrangement" to include those employment situations where payment is on a per-visit or per-unit basis, is reasonable based on the ambiguous language of the statute, the clear congressional intent to control costs and abuses by limiting fee-for-service compensation, and the Secretary's concern about the possibility of providers circumventing that intent through what would appear to be employment relationships.

The language of §1403 of the PRM specifically addresses two types of "employment" situations, i.e., 1) the "newly salaried" employees which the Secretary closely scrutinizes to make sure that an "employment situation is not being used to circumvent the guidelines," and 2) the "fee-for-service" compensated employees, which the Secretary treats as "nonsalary arrangements." As noted above, the Secretary's treatment of the latter situation, as a nonsalary arrangement, reflects the agency's assumption that such a compensation arrangement is subject to the same possible abuses that arise in the situation of the use of an outside contractor. Section 1403 of the PRM is therefore CMS's attempt to further congressional efforts to prevent such abuses, whether they arise through a clear outside contractor situation or through a hybrid employment/contractor situation, as in this case.

As reflected at §1403 of the PRM, the Secretary believed that either way, the possibility of abusing the program for greater reimbursement was the same, and could reasonably be prevented using the same imposed compensation limits. Contrary to the Board's opinion, whether the therapist is an employee of the Provider or receives benefits from the Provider which employees typically receive, are not the significant factors in this case. To base the decision of whether the Guidelines apply simply by examining the form of the employment relationship, rather than by exploring its substance, would facilitate the types of program abuses which Congress was trying to prevent in its adoption of §1861 (v)(5)(A) of the Act.

Consistent with the above, the Administrator notes that the Secretary has amended her regulations, reiterating the long-standing policy of treating fee-for-service therapist services as "under arrangement" situations. The 1998 amendments to the regulation at 42 CFR 413.106(c)(5) provide that:

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[8] *See Chevron U.S.A., Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). Where a statute is silent or ambiguous on the issue in question, the interpretation of the agency charged with administering the statute is entitled to deference as long as it is a reasonable one.

> If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

The Secretary explained in the preamble to the proposed rule of the above regulation at 42 CFR 413.106(c)(5) that:

> We are proposing to revise §413.106(c) to add a new paragraph (c)(6) that would provide that salary equivalency guidelines will apply in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission). The entire compensation would be subject to the guidelines in cases where the nature of the arrangements are most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The guidelines would be applied in this situation so that an employment relationship is not being used to circumvent the guidelines.
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> Since June 1977, there has been longstanding governing policy at section 1403 of the Provider Reimbursement Manual, Guideline Application, regarding this issue for making payments to providers…. This instruction clearly requires the intermediary to apply the salary equivalency guidelines in cases where the provider is paying the physical therapists on a fee-for-service basis. This instruction considered the nature of those arrangements and that they are most like an under "arrangement" situation, although technically they are employees. Therefore, the instructions further the statutory purpose as reflected in the legislative history of the salary equivalency guidelines. This instruction addresses the fact that HCFA recognizes that certain employment relationships would effectively circumvent the guidelines and provided for these circumstances in section 1403 of the Provider Reimbursement Manual.[9]

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[9] 62 Fed. Reg. 14851, 14871 (Mar. 28, 1997)(proposed rule); *see also* 63 Fed. Reg. 5106, 5126 (January 1, 1998)(final rule).

The Administrator finds that the foregoing regulatory language reflects a clarification in regulation of longstanding Medicare interpretative policy. Section 1403 of the PRM interprets and clarifies existing legislation and regulatory instruction regarding the Guidelines' applicability to physical therapist compensation paid under arrangements. Moreover, in this case, as discussed above, the policy of applying the Guidelines to fee-for-service arrangements has been in §1403 of the PRM since 1977.

The Board found that the Intermediary failed to prove that the costs for its employee physical therapists are substantially out of line with physical therapy costs paid by similar home health agencies. However, the regulation at 42 CFR 413.106(c)(5) provides that these costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service. The Administrator notes that the Provider's physical therapy costs exceeded the Guidelines. The Secretary has determined that in such circumstances the Provider's rate per visit was not what a prudent and cost conscious buyer would pay for the given service. However, rather than an irrebuttable presumption of unreasonableness, the Secretary in fact allows Providers to demonstrate that they are entitled to exceptions to the application of the Guidelines under certain circumstances.

Finally, the Administrator notes that the Court of Appeals for the Eighth Circuit holding in *In Home Health*, is not controlling in this case. The Provider is not located in a State which comprises the Eighth Circuit.

DECISION

The Board's decision is reversed consistent with the foregoing opinion for Issue No. 1. The Board's decision is summarily affirmed for Issue No. 2.

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

Date: 11/22/05 /s/

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