PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D27

PROVIDER –
Total Quality Home Care, Inc.
Alhambra, California

Provider No. 55-7633

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Cahaba Government Benefits
Administrator

DATE OF TELEPHONIC HEARING -
November 17, 2000

Cost Reporting Period Ended
December 31, 1997

CASE NO. 99-3872

INDEX

ISSUES:

1. Was the Intermediary's adjustment disallowing unsupported compensation paid to the Medical Director proper?

2. Was the Intermediary's adjustment reducing compensation paid to the Director of Nursing to a reasonable amount proper?

3. Was the Intermediary's adjustment to the Administrator's salary proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Total Quality Home Care, Inc. ("Provider") is a freestanding home health agency ("HHA") located in Alhambra, California. The Provider provides services primarily to a lower socioeconomic minority population in Los Angeles County. Wellmark Blue Cross and Blue Shield ("Intermediary")[1] issued a Notice of Program Reimbursement ("NPR") dated March 25, 1999 for fiscal year ended ("FYE") December 31, 1997. On August 20, 1999, the Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of these regulations for this appeal. With the exception of the issues as stated above, all other issues have either been withdrawn or administratively resolved.[2] The Medicare reimbursement impact of the above issues is approximately $87,054.[3] The Provider was represented by David Albin, M.D. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

Issue No. 1 – Medical Director
FACTS:

In its as-filed cost report, the Provider claimed $26,114 in compensation paid to its medical director. The Intermediary's Adjustment 11 disallowed this cost based on its assertion that it was unsupported, Intermediary Exhibit I-1. It should be noted that Adjustment 11 is a multi-part adjustment. The portion of this adjustment related to the Director of Nursing's reasonable compensation will be discussed under Issue 2 below.

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[1] The current Intermediary is Cahaba Government Benefits Administrators.

[2] At the hearing, the Intermediary agreed to reverse adjustments related to consulting fees and auto expenses. See Transcript ("Tr.") at 8-10. Issue Number 3 above, related to the Administrator's compensation, was added by the Provider after the initial appeal was filed. It was not briefed in the Intermediary's Position Paper.

[3] Intermediary Position Paper at 7: Provider Position Paper at 11.

PROVIDER'S CONTENTIONS:

The Provider contends that the salary of the medical director is reasonable. The Provider points out that the medical director was paid a salary of $20,000 plus fringe benefits for working 4 hours per week, 4 weeks per month. This amount is approximately $104 per hour. The Provider asserts that the Intermediary initially denied the entire amount of the medical director's salary due to an error on the Provider's accountant's worksheet; however, when the error was cleared up, the Intermediary stood by its adjustment.

The Provider believes that the Intermediary's adjustment is based on the presumption that because the medical director's work hours are on Monday evenings from 5:00-9:00 p.m., the medical director cannot function as a true medical director.[4] The Provider also argues that the Intermediary's assertion that the medical director did not work on Monday holidays lacks foundation. The Provider contends that the medical director did in fact work on holidays.

The Provider asserts that the medical director performed activities that improved the quality of patient care. The Provider further asserts that the medical director also reviewed patient charts. The Provider contends that the lists of patient charts reviewed by the medical director has been previously submitted to the Intermediary and are also enclosed with its Position Paper. [5]

The Provider also disagrees with the Intermediary's opinion that the medical director's time logs were not contemporaneous because the logs were generated by a computer. The Provider asserts that this opinion lacks validity. The Provider contends that it has been generating a computerized schedule for physicians long before 1997.

The Provider also points out that the medical director attended agency meetings; however, the Intermediary has refused to pay for them, as well. The Provider contends that it has attached supporting documentation it its Position Paper.

The Provider asserts that out of the 16 hours per month worked by the medical director, 2 hours went to community service and 14 hours were spent on chart review.[6] The Provider is requesting that it be reimbursed for 14 out the 16 hours worked by its medical director.[7] The Intermediary disallowed 100 per cent of the medical director's salary. The Provider asserts that the Intermediary has agreed to pay the Provider for 14 hours.[8] The Provider has requested a rate

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4 Provider Position Paper at 2.

5 See Medical Director's calendar at Medical Director Folder in Provider's Position Paper.

6 Provider Position Paper at 3.

7 Provider Post Hearing Brief at 1.

8 Id. See also Tr. at 61.

of $100 per hour and asserts that the rate will be determined by the Centers for Medicare and Medicaid Services ("CMS").[9]

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that this adjustment was made in accordance with the Provider Reimbursement Manual, Part I ("CMS Pub. 15-1") § 2304, Adequacy of Cost Information, which states that:

> [c]ost information as developed by the provider must be current, accurate and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

The Provider claimed $26,114 in medical director compensation paid to the wife of the owner. The Intermediary points out that the medical director is an OB-GYN in private practice. The Intermediary contends that the Provider did not have a contract or maintain invoices to support the amounts paid for the medical director's services or the nature of services rendered.

The Provider submitted the time record included as Intermediary Exhibit I-2 as support for services rendered by the medical director. This time record shows that the medical director worked every Monday evening from 5:00 to 8:00 p.m. The Intermediary asserts that the following problems were noted with this time record:

> 1. The hours worked and descriptions of activities performed were exactly the same on an alternating basis throughout the year.
> 2. Two descriptions were used on an alternating basis to describe activities performed at 5:00p.m. One of these descriptions, "Community Education," appears to be a nonallowable activity.
> 3. The exact same description, "HH", was used to describe activities performed at 6:00, 7:00 and 8:00p.m. every Monday. This description is not sufficient for the Intermediary to determine that allowable activities were performed.
> 4. It was noted that Memorial Day and Labor Day were included as days worked on this time record. Additionally, it is questionable that a practicing obstetrician would have been available to the Provider during the exact same hours every Monday evening during the year. It is unlikely that this physician would not have been called away on several occasions during these hours during

[9] Provider Post Hearing Brief at 1.

> the course of the year.
> 5. This computer generated time log does not appear to have been maintained on a contemporaneous basis; it appears that this log was produced at some point after the end of the time period in question.

Intermediary Position Paper at 8-9.

For these reasons, the Intermediary does not believe the submitted time log is accurate or reliable. The Intermediary also believes that the time spent by the medical director on community education activities is nonallowable. It is the Intermediary's position that the Provider was unable to provide auditable, credible evidence of work performed by the medical director, or even a contract or invoices to support the amount paid for her services. Therefore, the Intermediary determined this cost to be unsupported, and accordingly, adjusted to disallow the entire amount.

Issue No. 2 – Director of Nursing
FACTS:

In its as-filed cost report, the Provider claimed $88,341 paid to the Director of Nursing ("DON"). The Intermediary determined $26,563 of this compensation to be unreasonable and made an adjustment to disallow this portion. Intermediary Exhibit I-1.

PROVIDER'S CONTENTIONS:

The Provider claimed $88,341 in compensation for its DON. This included salary, health insurance, pension plan and bonus. The Intermediary determined that only $61,778 of the compensation was reasonable.

The Provider argues that in the prior cost reporting year, FYE 12/31/96, it performed over 5,000 visits, and the Intermediary allowed compensation for the DON in the amount of $78,000. The Provider argues that this amount, based on the 1996 Medicare audit, became its benchmark for the DON's 1997 salary.[10]

As background in support of the DON's salary in this case, the Provider contends that during the 1996 Medicare audit, the Intermediary challenged and subsequently accepted the salary of the same DON to be $78,000. The Provider notes the following summation of the explanation given to the Intermediary at the time of the 1996 audit to support the DON's salary:

> [w]hen I started my Home Health Agency, I interviewed approximately 12 candidates and received the following information with regard to salaries acceptable for the Director of

[10] Provider Position Paper at 5.

Nursing in the Los Angeles County area:
- A DON would work at the agency having the minimum of two years experience in Home Health for $5,000/month ($60,000 per year).
- A DON would with work at the agency with 2 to 5 years experience in Home Health for $6,000/month ($72,000 per year).
- A DON would work at the agency with 20 years experience in Home Health for $7,000/month ($84,000 per year).

The Provider contends that its DON has over 20 years experience in the field of home health.

The Provider offers the following argument for increasing the DON's salary and benefits in the current year to $88,341:

1. Increase in the number of visits from over 5,000 visits to over 9,000 visits. The Provider contends that the DON was not compensated for the increase in volume of visits and the work associated with the volume increase.
2. The DON was on first beeper call for patients every other night the entire year and was never paid for this service.
3. The DON was on second beeper call for patients every other night the entire year and was never paid for this service.
4. The DON was never once paid for overtime. The DON frequently worked nights and Saturdays.
5. The DON made home health visits to patients on Saturdays and was never paid for this service.
6. The DON shared financial responsibilities in absence of the chief financial officer.

The Provider also asserts that the DON is not related to the Provider's owner.

The Provider also contends that the $88,341 requested for the DON is within the average amount that the Intermediary had allowed for DONs in 1997 in Los Angeles County according to the 101 HHA cost reports reviewed by the Provider. The Provider disputes the Intermediary's contention that the high salary for DONs in the Provider's region was $58,200. To support its position, the Provider requested from the Intermediary, under the Freedom of Information Act, the 1997 cost reports and adjustments for all home health agencies serviced by the Intermediary in Los Angeles County.[11] The Provider notes that it received 101 cost reports from the Intermediary and summarized the results as follows:

In P-Chart 1, the Provider analyzed the salaries of DONs. The Provider notes that the

[11] Provider Position Paper at 4. The Provider's summary findings from analyzing these cost reports are included in the record at P-Chart 1, P-Chart-2 and P-Chart 3.

Intermediary contends that the high salary for DONs in the Provider's region was $58,847; however, the Provider's analysis notes that only a few salaries were below this amount. The Provider contends that the majority of the salaries were above this amount. The Provider also contends that agencies with a DON salary below $58,847 had a DON who worked part-time. See FTE designation in P-Chart 1.

The Provider's analysis also included a review of DON salaries relative to the number of Medicare visits. See P-Chart 2. The Provider notes that several agencies with a similar number of visits as the Provider employed a DON with a salary over $80,000.

Lastly, the Provider points to its analysis of DON salaries expressed in terms of cost per visit. See P-Chart 3. The Provider contends that its DON cost per visit rate is $9.37, which according to the cost report data, was well within the average range of other agencies in Los Angeles County. The Provider contends that its review of the Los Angeles County 1997 HHA cost reports demonstrated that the Intermediary was inconsistent in the salaries allowed for DONs. The Provider further contends that the Homecare Salary and Benefit Report ("Michigan Study") was obviously not followed by the Intermediary, since there were no two agencies in which the DON received similar treatment with regard to the payment of salaries.

It is the Provider's position that its analysis of the 1997 Los Angeles County cost reports supports its contention that there were Intermediary discrepancies in the amounts allowed for DONs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment reducing the DON's salary to a reasonable level was made in accordance with 42 C.F.R. §§ 413.9 and 413.102, and CMS Pub. 15-1, Chapter 9. The Intermediary cites 42 C.F.R. § 413.9 which states that:

> [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.

The Intermediary also cites CMS Pub. 15-1 § 901 which states that:

> [t]he allowance of compensation for services of sole proprietors and partners is the reasonable value of the services rendered. The test of reasonableness applies to the actual compensation of all

> individuals performing services in connection with the operation of a provider including: (1) employees, officers, and directors owning stock in closely-held corporations; (2) employees, officers, and directors with a substantial ownership or equity in public corporations; and (3) certain employees of trusts (see Sec. 902.6).

Therefore, it is the Intermediary's position that the above section of CMS Pub. 15-1 applies to compensation of employees other than owners, including the Provider's DON. The Intermediary contends that 42 C.F.R. § 413.102(c)(2) allows it to determine reasonable compensation by "other appropriate means." This regulation provides, in part that:

> [r]easonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means.

Id. (Emphasis added.)

As stated above, the Intermediary contends that 42 C.F.R. § 413.102(c)(2) allows it to determine reasonable compensation by "other appropriate means." To satisfy its contractual obligation to CMS, the Intermediary contends that it used an alternative method which consisted of comparing the compensation in question to healthcare salary surveys. The Intermediary asserts that it used the Michigan Study to determine reasonable compensation for the Provider's DON position.

The Intermediary contends that the survey shows that the high salary for DONs in the Provider's region was $58,847. The survey also shows that the high salary for providers in the same region with revenues similar to the Provider (less than $1,000,000) was $58,200. The Intermediary notes that it chose to use the higher of these figures in determining reasonable compensation for the DON. The reasonable salary amount of $58,847 was compared to the claimed salary of $84,150. The Provider's DON salary was $25,303, or 43 percent higher than the high salary noted on the survey for DONs of other similarly situated providers.

Therefore, the Intermediary determined that the DON's salary was significantly out-of-line and an adjustment was needed. The Intermediary adjusted to disallow the $25,303 of salary in excess of the reasonable amount as well as $1,260 in benefits calculated using the ratio of unreasonable compensation to total. A total of $26,563 was disallowed for the DON.

The Intermediary asserts that it has fulfilled its responsibility to determine reasonableness. It has obtained, by survey, a range of compensation for comparable institutions and applied these to the Provider in making the final settlement.

The Intermediary contends that, if the Provider wishes the Board to disregard the Michigan Study, it has the burden to produce evidence of the reasonableness of the claimed compensation. The Intermediary believes its adjustment is in accordance with Medicare guidelines. Therefore,

the Intermediary requests that the Board affirm its adjustment.

Issue No. 3 – Administrator's Salary

Facts:

The Provider claimed $131,929 in Administrator's compensation, and the Intermediary allowed $84,229.[12] The Intermediary used an allowable amount of $91,629 derived from the Michigan Study of administrators' compensation, added a wage index adjustment of 22.57 percent and then reduced this amount based on its assertion that the Provider's Administrator only worked 75 percent of the time. The 75 percent was derived from an Intermediary summary of time studies for the Administrator.

PROVIDER'S CONTENTIONS:

The Provider contends that its Administrator was in fact a full time employee and that the Intermediary erred in summarizing the Administrator's hours on the time studies.[13] The Intermediary acknowledged at the hearing that there were some errors in its summary of the hours.[14] The Provider contends that its Administrator was a full time employee and that the claimed salary should be restored to 100 percent.

The Provider further contends that the Intermediary has reduced the Administrator's compensation to less than that of a full time employee because the Intermediary does not consider the Administrator's lunch hour to be official paid time.[15] The Provider contends that the Intermediary is violating California labor law which states, according to the Provider, that employees who work 7 hours are to be paid an additional 1 hour of compensation.[16]

The Provider acknowledges that at the time of the audit it did not provide the Intermediary with any documentation to challenge the Michigan Study administrator amounts; however, since then it has performed an analysis of administrators' compensation from 101 Los Angeles County 1997 HHA cost reports and has included this summary with its Position Paper to support its claimed cost.[17]

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[12] Intermediary Exhibit I-1 at 3-6A, at 1.

[13] See Tr. at 39-40, 59 and 63-64.

[14] Tr. at 59.

[15] Provider's Post Hearing Brief at 4.

[16] Id.

[17] See Provider Chart IV.

Based on the above, the Provider believes that the Board should reverse the Intermediary's adjustment and allow 100 percent of the Administrator's compensation claimed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary acknowledges that had it recognized the Administrator as a full time position, it would have allowed a compensation amount of approximately $91,000, based on the Michigan Study.[18] However, based on its review of the Administrator's time studies, the Intermediary determined that the Administrator was only a 75 percent employee and adjusted the salary accordingly.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Costs Related to Patient Care
§ 413.102 et seq.	-	Compensation of Owners

2. Provider Reimbursement Manual, Part I (CMS Pub. 15-1):

§ 901 et seq.	-	Compensation of Owners
§ 2304	-	Adequacy of Cost Information

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, testimony elicited at the hearing, evidence submitted, parties' contentions and the Provider's post hearing brief, finds and concludes as follows:

Issue No. 1 - Medical Director

The Board finds that the allowability of compensation for the Provider's medical director is directly related to the issue of proper documentation. The Board notes that the Provider included evidence in the record that included details of the medical director's weekly calendar.[19] Based

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[18] Tr. at 57-59; Intermediary Exhibit I-1 at 3-6A, at. 1.

[19] See Medical Director calendar in Medical Director folder in Provider Position

on this evidence, the Board finds that the medical director routinely worked 14 hours per week on direct patient services reviewing patients' medical charts. The Board notes that the type of documentation found in the medical director's calendar is the same type of documentation that is typically used as support in Graduate Medical Education type issues.

The Board also finds that the Intermediary witness stated that although he had not yet seen the calendar, he would have accepted the medical director's calendar, along with the names of patients whose charts were reviewed, as documentation for allowing the claimed hours.[20]

While the Intermediary did not raise the issue of reasonable compensation equivalents (RCEs), the Board feels it is appropriate to apply RCEs in this case. The Board concludes that the Intermediary's adjustment should be modified with the proviso that RCEs be applied to 14 hours per month

Issue No. 2 - Director of Nursing:

The Board finds that this issue revolves around its interpretation of the salary surveys submitted into evidence by both parties. The Board finds that the Provider submitted into evidence its summary and analysis of 1997 Los Angeles County HHA cost reports.[21] The Board also finds that the Provider attempted to use its analysis of salaries contained in these cost reports to support the amount of salary claimed for its director of nursing. The Board further finds that the Intermediary's adjustment was based primarily on the Michigan Study and supported by a National Association for Home Care salary survey.[22]

The Board finds that the Provider's argument to support the DON's salary was based on what it perceived to be comparable director of nursing salaries from Column 2, Worksheet A-1 of the Los Angeles County cost reports it reviewed. The Board notes, however, that Column 2 of Worksheet A-1 is titled "Directors" and is, therefore, a questionable interpretation by the Provider, since this column does not specifically refer to its contents as "Director of Nursing" salaries.

The Board also notes that the Provider included in its Post Hearing Brief a California Association for Health Services at Home ("CAHSAH") salary survey of director of nursing salaries for 1996 and 1998. The Board finds that the salary levels indicated in the CAHSAH surveys are comparable to what the Intermediary has allowed the Provider for its DON. The Board further notes that the Intermediary awarded the Provider the highest DON salary indicated

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Paper.

[20] Tr. at 61.

[21] See P-Chart 1, P-Chart 2 and P-Chart 3.

[22] See I-1 at 3-6B.

in the Michigan Study for the visit size and revenue range comparable to the Provider.

Accordingly, based on the best evidence in the record, the Board concludes that the Intermediary's adjustment was reasonable.

Issue No. 3 - Administrator's Salary

The Board finds that the core of this issue again revolves around its interpretation of the salary surveys submitted into evidence by both parties. The Board notes that the Intermediary submitted information from the Michigan Study and used this survey as a basis for its adjustment. After determining what it perceived to be a reasonable salary based on the Michigan Study, the Intermediary reduced this amount based on a review of the Administrator's time. The Intermediary's audit of the Administrator's time indicated that the Administrator only spent 75 percent of his time working for the Provider.[23]

The Board also notes that the Provider attempted to substantiate the reasonableness of the Administrator's salary in Provider Chart P-4. The Board notes, however, that the range of administrators' salaries from the other agencies indicated in this chart does not support the amount claimed by the Provider. The Board finds that the Provider's summary of administrators' salaries actually adds credence to the amount used by the Intermediary from the Michigan Study.

As noted above, the Intermediary further reduced the Michigan Study salary amount based on its analysis of the Administrator's time. During testimony, the Intermediary witness acknowledged errors in the summary of this analysis.[24] Following up on the Intermediary's acknowledgement of errors in the summary, a Board member commented on the accuracy of the "75 percent" that the Intermediary derived from this analysis.[25] Accordingly, the Board member requested the Intermediary to recalculate this percentage and submit the results with its post hearing brief. The Board notes that the Intermediary failed to submit a post hearing brief or a re-calculation of the "75 percent." Without these submissions, the Board has no choice but to conclude that the Intermediary has failed to substantiate the "75 percent." Therefore, the Board finds that it agrees with the Provider's argument that its Administrator was a 100 percent full time employee.

The Board further concludes that the best evidence in the record regarding administrator salaries was the Michigan Study information used by the Intermediary. The Board therefore finds that the Intermediary's salary adjustment based on this survey was reasonable.

In summary, the Board is modifying the Intermediary's adjustment to allow 100 percent of the

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[23] See Intermediary Exhibit I-1, 3-6A-2, at 1-22.

[24] Tr. at 59.

[25] Tr. at 63-64.

salary and wage index adjustment as indicated in the Michigan Study and eliminating the "75 percent" time adjustment used by the Intermediary.

DECISION AND ORDER:

Issue No. 1 - Medical Director

The Intermediary's adjustment of 100 percent of the medical director's compensation was improper. The Intermediary's adjustment is modified to allow 14 of the 16 claimed monthly hours for the medical director with RCEs applied to these hours.

Issue No. 2 - Director of Nursing

The Intermediary's adjustment reducing the director of nursing's salary to be more in line with comparable salaries for directors of nursing in the Michigan Study was reasonable. The Intermediary's adjustment is affirmed.

Issue No. 3 - Administrator's Salary

The Intermediary's two part adjustment reducing the Administrator's compensation to an amount based on the Michigan Study and then further reducing this amount based on a time study of the Administrator's hours was improper. The Intermediary's adjustment is modified as follows: 1) to affirm the portion of the adjustment reducing the compensation to the amount indicated in the Michigan Study and 2) to reverse the Intermediary's portion of the adjustment for time.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Gary B. Blodgett, D.D.S.
Suzanne Cochran, Esquire

Date of Decision: July 09, 2002

FOR THE BOARD

Irvin W. Kues
Chairman