PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2004-D11

PROVIDER –
Incare Home Health, Inc.
Myrtle Beach, South Carolina

Provider No. 42-7025

vs.

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

DATE OF HEARING -
November 24, 2003

Cost Reporting Period Ended
September 30, 1996

CASE NO. 99-3324

INDEX

ISSUES:

1. Was the Intermediary's adjustment to Board of Directors fees proper?
2. Was the Intermediary's adjustment to routine and non-routine supply costs proper?

STATEMENT OF CASE AND PROCEDURAL HISTORY:

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and what proportion of those costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 42 C.F.R. §405.1803. A provider dissatisfied with the Intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Incare Home Health Care and Services, Inc. ("Provider") is a closely held corporation located in Myrtle Beach, South Carolina. The Provider is owned and managed by Medical Services of America, Inc., a home office which is located in Lexington, South Carolina. The Provider is serviced by Palmetto Government Benefits Administrators ("Intermediary").

The Provider was dissatisfied with the Intermediary's adjustments and requested a hearing before the Provider Reimbursement Review Board ("Board"). The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R §§405.1835-.1841. The amount of Medicare reimbursement at issue is approximately $89,200.

The Provider was represented at the record hearing by J. Scott McDearmon, Esq., of Grant, Kovalinka & Harrison. The Intermediary was represented by Bernard M. Talbert, Esq., the Blue Cross and Blue Shield Association.

ISSUE 1- DIRECTORS' FEES

FACTS:

The Intermediary denied $17,100 in fees paid to members of the Provider's Board of Directors for the fiscal year ended September 30, 1996. The Intermediary determined, based on prior audit results, that Board members' (directors) reimbursement should be limited to $100 per hour for actual time spent in the Board meetings.

PROVIDER'S CONTENTIONS:

The Provider points out that the Medicare regulations at 42 C.F.R §484.14(b) require that each Medicare certified provider maintain a governing body which assumes legal authority and responsibility for the operation of the agency. The governing body must appoint an administrator, arrange for professional consulting input from qualified medical personnel, ensure qualified personnel and adequate staff education and evaluation, ensure the accuracy of public information materials and activities and implement an effective budgeting and accounting system. The Provider argues that those duties cannot be fully discharged in the two-hour Board meetings.

The Provider further contends that the Intermediary failed to compare its Board of Directors' fees with fees paid by similarly situated providers. The Provider provided the Intermediary with a 1997/1998 compensation study by Marks & Wyatt Data Services entitled "Compensation for Outside Directors Providing Regular Board Services." The survey indicates that the lowest 25% of directors received $19,750 per year while the outside directors received $27,857. The Provider maintains that even with a modest discount for inflation over a one-and-one half to two-year period between the year ending September 30, 1996 and the median date of the survey results, the $2,850 payments to most Board members would constitute approximately 14% of the payments to the lowest quartile of directors in the survey.

The Provider argues that the individuals who serve as outside members of a Board of Directors assume potential liabilities in serving as directors. In the absence of some financial incentive, no Medicare provider could attract competent directors. Given the extensive duties placed upon the Board by 42 C.F.R §484.14 (b), the Intermediary's allowance of $750 per director -- approximately 4% of the amount the average director in the lowest paid quartile earned -- is unreasonable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not furnish any additional documentation to justify the directors' fees. There was no evidence supporting the value of directors' incidental activities or showing whether directors actively participated in the operations of the Provider or merely attended the directors meetings. Nor was there evidence as to the experience and backgrounds of the directors and the value each brought to the Provider. The Provider did not provide evidence to determine if the directors actively participated in budget meetings or merely approved the budget.

The Intermediary points out that in Dyna Care Home Health, Inc. v. Blue Cross and Blue Shield Association/Health Care Service Corporation, Inc., PRRB Dec. No. 98-D68, June 25, 1998, upheld in U.S. DC, Northern District of Illinois No. 98 c 5122, July 6, 1999, the Board stated:

> The secretary's disallowance of compensation for the HHA's non-shareholder directors was not arbitrary and capricious. The

> HHA did not provide sufficient documentation to determine the reasonableness of the directors' compensation.

In that case the provider submitted one set of minutes for a 1991 meeting and one set for a 1992 meeting. The intermediary's allowance of an annual $100 nominal fee for each non-employee board member was affirmed.

The Intermediary contends that it is the responsibility of the Provider to furnish documentation in accordance with 42 C.F.R. §§413.9, 413.20 and 413.24, as well as section 2304 of the Provider Reimbursement Manual, so that the Intermediary can properly determine the allowability of costs and apportionment methods used by the Provider. Since the Provider did not provide adequate documentation to support its arguments, the Intermediary utilized the best information available from the Provider's books and records to determine the proper amount of Medicare reimbursement

ISSUE 2 - SUPPLY COSTS

FACTS:

The Provider purchased $87,015 in medical supplies from Medi Home Health Agency, Inc. (Medi Home), which is affiliated with the Provider's consultant, Medical Services of America, Inc. The Intermediary contended that Medi Home was a related organization to the Provider and reduced the Provider's claimed routine and non-routine medical supply costs to the actual costs of the related organization, Medi Home. The related organization principle, found at 42 C.F.R. §413.17, allows reimbursement of costs paid by a provider to a related organization for services or supplies, but limits those to the actual cost paid by the supplying organization, with the additional requirement that the cost not exceed the price of comparable services or supplies that could be purchased elsewhere.

An exception exists, however, to the related organization principle. If the provider satisfies four requirements, charges by the supplier related to the provider for the subject services or supplies are allowable as costs. The factors are as follows:

> (i) The supplying organization is a bona fide separate organization;
>
> (ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;
>
> (iii) The services, facilities or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care

ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

42 C.F.R. §413.17(d).

PROVIDER'S CONTENTIONS:

The Provider argues that it met the exception to the related party principle in that Medi Home's total sales to the Provider during the fiscal period at issue were $145,026, while its sales to other related parties were $1,633,848. Sales to all parties were $24,943,369.

The Provider maintains that the Intermediary erred when it concluded that the Provider failed to prove that a substantial amount of business was conducted with other outside organizations. The Provider points out that Medi Home's medical supplies sales were co-mingled with its Durable Medical Equipment (DME) sales. Only 0.5% of Medi Home's sales were to the Provider. Overall, only 6.55% of Medi Home's sales were to related parties. Where a supplying organization conducts over 93% of its business with unrelated parties, that organization does a substantial part of its business activity with those unrelated parties.

The Provider maintains that the Intermediary erred in its calculation of the cost of the medical supplies Medi Home sold to the Provider. If an adjustment were necessary, the amount of the adjustment should have been limited to $20,840, the actual profit to Medi Home of 16.78%.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider was unable to separate Medi Home's sales between DME and medical supplies. The Intermediary determined that the related organization was unable to document that a substantial part of its business activity was transacted with parties other than the Provider for the sale of medical supplies that were not DME related. The Intermediary points out that the Provider did not demonstrate with any evidence that the reduction of related organization charges to cost was inaccurate or unacceptable for cost reporting purposes.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, parties' contentions and evidence submitted, finds and concludes the following:

DIRECTORS' FEES

The Intermediary properly adjusted the Directors' fees.

The Board finds that the Provider's Board of Directors were also "key officers of the home office," a related organization, and that some of the board members were paid consultants to the Provider. The Board finds that the study of Directors' salaries, which the Provider presented in its contentions, was not persuasive of reasonable director fees. There was no indication of what data went into the study or that the figures produced by the study were representative of the Provider. The study did not indicate the size or area of the population but only stated that it was a "Health Care Study." It did not include the types of facilities, the scope of services performed or the size and area of the facilities contained in the study. In addition, there was no evidence as to whether the study participants were publicly traded or closely held facilities.

The Board finds that the Provider's argument that the directors did more than attend meetings as justification of their fees was not supported by the evidence. Absent sufficient documentation to support the fees paid to the directors, the Board concludes that the Intermediary's adjustment of the fees is proper.

SUPPLY COSTS

The Intermediary properly adjusted the Provider's supply costs.

The Board finds that the Provider failed to support its position that it is entitled to an exception to the related organization principles enunciated at 42 C.F.R. §413.17(d). The related party vendor's sales of routine and non-routine supplies were commingled with its sales of DME in such a way that it was impossible to determine the amounts of supply sales to unrelated parties. Furthermore, what summary evidence there is in the record is not supported by any form of source data. Finally, the Provider failed to provide copies of the supplying organization's financial statements and sales journal that may have supported its claimed mark-up percentages and the amount of supply sales to unrelated parties.

The Board finds that the Provider's contention that it is entitled to an exception to the related organization regulation is without merit.

DECISION AND ORDER:

Directors' Fees

The Intermediary properly adjusted the fees of the members of the Provider's Board of Directors. The Intermediary's adjustment is affirmed.

Supply Costs

The Intermediary's adjustment to the Provider's supply cost was proper. The Intermediary's adjustment is affirmed

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

FOR THE BOARD

DATE: February 5, 2004

Suzanne Cochran
Chairman