PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D24

PROVIDER –
Nurses Registry Home Health, Inc.
Harahan, Louisiana

Provider No.: 19-7545

vs.

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

DATE OF HEARING –
June 2, 2004

Cost Reporting Period Ended -
April 30, 1999

CASE NO.: 02-0183

INDEX

ISSUES:

1. Whether the Intermediary's adjustment to remove accrued salaries for owners due to payment not being properly liquidated within 75 days after the close of the cost reporting period was proper.

2. Whether it was proper for the Intermediary to disallow the portion of the accrued owners' compensation expenses attributable to the employees' share of Federal and State withholding taxes.

STATEMENT OF THE CASE AND STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare payments to a health care provider.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services charged with the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and under interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report and determines the total amount of Medicare reimbursement due the provider, and notifies the provider in a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Nurses Registry Home Health, Inc. (Provider) is a home health agency located in Harahan, Louisiana. At the close of its cost reporting period ended April 30, 1999, the Provider had accrued salaries payable amounting to $104,674. Palmetto Government Benefit Administrators (Intermediary) reviewed the Provider's cost report and found that the Provider had issued checks by July 14, 1999 to liquidate this entire amount. However, the Intermediary also found that certain of the checks amounting to $35,754 payable to the Provider's owners, although issued within 75 days after the close of the cost reporting period, had not cleared the bank within that period. In response, the Intermediary made an adjustment to the Provider's cost report disallowing the $35,754 because an actual transfer of the Provider's assets had not occurred within 75 days after

the close of the cost reporting period. The adjustment was based upon the following rules:

Regulations at 42 C.F.R. §413.100(c)(2)(iv):

> *Compensation of owners.* Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated within 75 days after the close of the cost reporting period in which the liability occurs. (Emphasis added).

Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §906.4, amended February 1996 (Transmittal No. 391), effective with cost reporting periods beginning on or after October 1, 1995:

> [t]he compensation of stockholder-employees and individuals described in §901 (other than sole proprietors and partners) is included for a cost reporting period if earned within the period, even if not paid until after the close of the period. However, payment must be made (whether by check or other negotiable instrument, cash or legal transfer of assets such as stocks, bonds, real property, etc.) within 75 days after the close of the period. Where payment is made by check or other negotiable instrument (e.g., a promissory note), these forms of payment must be liquidated through an actual transfer of the provider's assets within 75 days after the close of the period in order to meet the requirements of this section. If payment, including the liquidation of negotiable instruments, is not made within the cost reporting period, or within 75 days thereafter, the unpaid compensation is not includable in allowable costs either in the period when earned or in the period when actually paid. (Emphasis added).

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $35,396.[1]

The Provider was represented by John W. Jansak, Esq., of Harriman, Jansak & Wylie. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the requirement in Transmittal No. 391 that an actual transfer of assets be made within 75 days after the close of a cost reporting period (in order for accrued compensation to be an allowable cost) is illegal. This requirement is inconsistent with the controlling authority of 42 C.F.R. §413.100(c)(2)(iv) which only requires that "liquidation" occur within 75days. The "actual transfer of assets" requirement that was

[1] Provider Position Paper at 2. Intermediary Position Paper at 4. Exhibit I-1.

added to the Provider Reimbursement Manual via Transmittal No. 391 was a significant change that required an amendment to the regulation in accordance with the Administrative Procedure Act. Furthermore, any manual provision that is inconsistent with the regulation it purports to interpret must be struck down, as it was not properly issued. Virterelli v. Seaton, 359 U.S. 535.

The Provider contends that the term "liquidation" as used in the regulation is commonly defined as payment of a debt. Under various circumstances a debt is considered liquidated as of the date of issuance of a check. See e.g., Brady on Bank Checks, Revised edition at ¶ 4.06.

The Provider contends that $14,542 of the Intermediary's adjustment to accrued owners' compensation is related to State and Federal withholding taxes and that these employment-related taxes are allowable costs pursuant to HCFA Pub. 15-1 §2122.3.[2] Moreover, these taxes must be paid to their respective government entities regardless of whether or not Medicare recognizes the related salaries as allowable costs. In accordance with IRS rules, the taxes were withheld when the related compensation checks were issued. These withholdings are not part of the checks written to the Provider's owners and are not subject to the 75-day rule.

The Intermediary contends that program rules at HCFA Pub. 15-1 §906.4, as amended by Transmittal No. 391, specifically require accrued owners' compensation to be liquidated through an actual transfer of assets within 75 days after the close of a provider's cost reporting period. Therefore, all of the Provider's checks needed to clear the bank by July 14, 1999, which did not happen. Moreover, Transmittal No. 391 did not impose new rules that were inconsistent with the regulations. Rather, the Transmittal clarified the term "liquidation" consistent with the provisions of HCFA Pub. 15-1 §2305, which specify the timeframes and requirements for the liquidation of negotiable instruments. The Intermediary cites the Board in Continue Care Home Health II. Inc. v. Palmetto Government Benefit Administrators, Dec. No. 2001-D48, August 22, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,744, Decl'd Rev., CMS Administrator, November 1, 2001, holding that "CMS requires that payments must be liquidated within 75 days of the closing of the cost reporting period. Liquidation is the actual transfer of assets not mere delivery of a check."[3]

Regarding the $14,542 portion of the disallowance, the Intermediary contends that the tax liability at issue is that of the Provider's owners and not that of the Provider. The Provider was merely holding the funds until they were properly deposited with the appropriate government agency. The Provider did, however, expense the gross amount of the salaries, $35,754, which is properly at issue and should be disallowed.[4]

[2] Provider's Supplemental Position Paper at 2.
[3] Intermediary Position Paper 6. Exhibit I-6.
[4] Intermediary's Supplemental Position Paper at 6.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds that the Intermediary properly disallowed the owners' compensation expense accrued by the Provider at the end of its Medicare cost reporting period. Although the Provider had issued checks within 75 days after the end of the reporting period to liquidate the accruals pursuant to 42 C.F.R. §413.100(c)(2)(iv), the checks had not cleared the Provider's bank within that period. Accordingly, the accrued expenses are unallowable pursuant to HCFA Pub. 15-1 §906.4, which, as amended by Transmittal No. 391, requires accrued compensation to be liquidated through an "actual transfer" of the Provider's assets within the 75-day period.

The Board disagrees with the Provider's argument that the transfer of assets requirement implemented through Transmittal No. 391 is illegal because it is inconsistent with the pertinent regulation. The Board notes that the Provider had been held to the transfer of assets requirement, since Transmittal No. 391 was issued in February 1996. In addition, the transfer of assets requirement contained in Transmittal No. 391 is a reiteration of existing policy. At one time, regulations at 42 C.F.R. §405.426(d) required accrued owners' compensation to be liquidated within 75 days after the close of a provider's cost reporting period for the accrued compensation to be included in allowable costs. Then, in 1983, HCFA stated that this requirement did not need to be incorporated in the regulations and that program instructions at HCFA Pub. 15-1 §2305 were sufficient to safeguard against abuse. 48 Fed. Reg. 39752, 39753 (Sept. 1, 1983). Notably, HCFA Pub. 15-1 §2305, which pertains to short-term liabilities, requires that where liquidation is made by check or other negotiable instrument, payment must be made "through an actual transfer of the provider's assets within the time limits specified." Accordingly, Transmittal No. 391 essentially reiterated existing policy.

The Board also disagrees with the Provider's argument that accrued expenses should be considered liquidated when a check for payment has been issued. The issuance of a check does not represent an actual transfer of assets, as a check may never be cashed or there may not be sufficient funds in the account upon which the check was drawn to allow the check to be cashed. There is no transfer of assets until the amount of the check has been withdrawn from the provider's bank account.

Finally, the Board disagrees with the Provider's argument that the Federal and State withholding tax portions of the Intermediary's adjustment were improper, since they were not associated with the checks issued to its owners and, therefore, not subject to Medicare's 75-day rule. The Board finds that the program's rules regarding accrued owners' compensation apply to the total salary expense included in a provider's cost report. This expense (compensation) includes the gross amount earned by the owners and claimed for program reimbursement rather than the amount paid net of payroll withholding taxes. The Provider is responsible for withholding all applicable payroll taxes and remitting them to the proper governmental agencies.

DECISION AND ORDER:

The Intermediary's adjustment disallowing accrued owners' compensation expenses that were not liquidated within 75 days after the close of the Provider's cost reporting period was proper. The adjustment properly included the portion of the accrued owners' compensation expenses attributable to the individuals' share of Federal and State employment taxes. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West

FOR THE BOARD:

DATE: February 11, 2005

Suzanne Cochran, Esq.
Chairman