PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D37

PROVIDER -
VNA Healthcare, Inc.
Centralia, Illinois

Provider No.: 14-7112

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
February 11, 2005

Cost Reporting Period Ended -
April 30, 1998

CASE NO.: 01-2620

INDEX

ISSUE:

Were the Intermediary adjustments applying Medicare's salary equivalency guidelines to services performed by Provider's employee physical and occupational therapists proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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 the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

VNA Healthcare, Inc. (Provider) is a home health agency (HHA) located in Centralia, Illinois. During the fiscal year May 1, 1997 to April 30, 1998, the Provider rendered physical, occupational and speech therapy services to patients. The therapists performing these functions were employees of the HHA and were compensated on a per visit basis. These employees were subject to payroll tax withholding and were covered by the agency's health insurance and retirement plans.

Cahaba Government Benefit Administrators (Intermediary) applied Medicare regulation 42 C.F.R. §413.106 – Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements – and HCFA Program Instruction (HCFA Pub. 15-1) §1403 – Guideline Application to the Provider's therapy costs. This resulted in a reduction of allowable physical therapy cost in the amount of $79,886. Occupational therapy cost was reduced by $2,104.

The Provider appealed these adjustments to the Board. The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Mr. Eric Thomas of ServiceMaster Home Healthcare Services. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, evidence and the parties' contentions finds as follows.

The Intermediary improperly adjusted the Provider's cost report by applying the physical and occupational therapy guidelines for therapy services provided "under arrangement" by outside contractors to the wages paid to the Provider's employee therapists. Although the Intermediary does not dispute that the therapists were employees of the Provider, it maintains that, according to Medicare guidelines, PRM1, Section 1403, "[In] situations where compensation, at least in part, is based on a fee-for-service basis or on a percentage of income (or commission), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter."

The Board concurs with the Provider's position that the U.S. District Court case for In Home Health, dated June 16, 1998 provides strong argument against allowing the reasonable compensation guidelines to be applied to employee compensation based on a fee per visit. The court decision stated in part:

> . . . 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. 42 U.S.C. §1395x(5)(A) reads: "Where physical therapy services … are furnished under arrangement with a provider of services or other organization … the amount included in any payment to such provider or other organization … as the reasonable costs of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which reasonably would have been paid for such services … to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement)…." (Emphasis added).
>
> The language of the Act distinguishes between services that are performed by employees of the provider and services that are performed "under an arrangement," and it indicates that services performed by a physical therapist in an employment relationship with the provider are different from those services performed "under an arrangement." The guidelines, therefore, do not apply to employee physical therapists who are paid on a fee-per-visit basis.

District of Minnesota, No 97-2598, June 16, 1998.

The decision of the District Court was subsequently affirmed by the U.S. Court of Appeals for Eighth Circuit, No. 98-3141, September 1, 1999.

See also, High Country Home Health, Inc. v. Shalala, U.S. District Court of Wyoming, No. 97-CV-1036-J, Dec. 20, 1999 (supporting the Board's decision denying application of the physical therapy guidelines to the Provider's salaried therapists.)

The Board finds that 42 U.S.C. §1395x(v)(5)(A) and 42 C.F.R. §413.106 provide no basis for the application of the guidelines to employee physical therapists. Both the legislative and regulatory history of Medicare Guidelines indicate that their purpose was to curtail and prevent perceived abuse in the practices of outside physical therapy contractors. The Board also notes that the term "under arrangement" is commonly referred to and used interchangeably with the term "outside contractor."

The Board also disagrees with the Intermediary's alternative argument that the Provider's therapy compensation should be disallowed because these costs were substantially out of line, citing the prudent buyer concept set forth in HCFA Pub. 15-1. First, the Intermediary asserts that since the Provider's physical therapy costs exceeded the limits in the physical therapy guidelines for outside contractors, that alone proves that the costs were unreasonable and were, in fact, substantially out of line. Second, the Intermediary compares the Provider's therapy compensation costs to the Hospital and Healthcare Compensation Service Survey (1998) to show that the Provider's costs were higher. The Board finds this analysis troubling, in that the Intermediary cites general regulations and program instructions (42 C.F.R. §413.9[1] and HCFA Pub. 15-1 §2103) despite the existence of very specific regulations relating to therapy costs (42 C.F.R. §413.106 and Chapter 14 of HCFA Pub. 15-1). If the Intermediary believes that the compensation paid to the Provider's employees was subject to the specific therapy guidelines addressed above, it is not appropriate to rely on general regulations and program instructions to deny such costs. Inherent in the specific regulations and program instructions are CMS' analysis and conclusions of what is reasonable and prudent regarding the specific type of cost being regulated–in this case, physical and occupational therapy costs.

The Board also finds that the survey the Intermediary used to support its prudent buyer analysis is seriously flawed, in that it:

- lacks detail sufficient to support its conclusions,
- includes responses from only thirty therapists,
- contains data that did not come from Medicare cost reports or other auditable reports or documents, and
- contains data that is not verifiable.

[1] This regulation is a general requirement that costs must be related to patient care and must be reasonable. It is the foundation of the prudent buyer concept at forth in HCFA Pub. 15-1 §2103.

Finally, there is no evidence in the record that the survey was submitted to CMS for approval as required by 42 C.F.R §413.106(b)(6), which states in relevant part:

> Other statistically valid data may be used to establish guidelines for a geographical area, provided that the study designs, questionnaires and instructions, as well as the resultant survey data for determining the guidelines are submitted to and approved in advance by CMS. Such data must be arrayed so as to permit the determination of the 75th percentile of the range of salaries paid to full-time employee therapists.

The Board concludes that since the survey was unreliable and unapproved, it is unreasonable for the Intermediary to rely upon it to limit the Provider's actual therapy costs.

DECISION AND ORDER:

The Intermediary improperly applied the reasonable compensation equivalency guidelines to the Provider's employed physical and occupational therapists who were paid on a fee-for-service basis. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: May 10, 2005

Suzanne Cochran
Chairperson