PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D70

PROVIDER -
Potomac Home Health Care
Rockville, Maryland

Provider No.: 21-7084

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
June 29, 2005

Cost Reporting Periods Ended -
June 30, 1995; June 30, 1996 and
June 30, 1999

CASE NOs.: 98-1725; 99-2325
and 02-1682

INDEX

ISSUES:

1. Whether the Intermediary's adjustment applying the Salary Equivalency Guidelines (SEGs) or "physical therapy compensation guidelines" to fee-for-service employee compensation was proper (Case Nos. 98-1725 (FYE 6/30/95) and 99-2325 (FYE 6/30/96)).

2. Whether it was proper for the Intermediary to make an adjustment reclassifying interest expenses. (Case No. 02-1682 (FYE 6/30/99)).

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.[1]

The parties appealed the below referenced physical therapy and interest adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. Potomac Home Health Care (Provider), was represented by Joel M. Hamme, Esq. of Powers, Pyles, Sutter and Verville, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

[1] On May 20, 2004, the parties in this case appeared before the Board and presented testimony relating to multiple disputed issues. During the hearing, the parties agreed to resolve most of the disputed issues. The parties agreed that the two unresolved issues (which are the subject of this decision) would be heard on the record.

ISSUE 1: Whether the Intermediary's adjustment applying the Salary Equivalency Guidelines (SEGs) (or "physical therapy compensation guidelines") to fee-for-service employee compensation was proper (Case Nos. 98-1725 (FYE 6/30/95) and 99-2325 (FYE 6/20/96)).

ISSUE 1: FACTUAL BACKGROUND:

The Provider is a Medicare-certified home health agency located in Rockville, Maryland. During the time period at issue, the Provider rendered home health services, including physical therapy, to its patients. The therapists were the Provider's employees and were paid on a per-visit basis.[2]

In its as-filed cost report, the Provider omitted salaries and visits performed by employee physical therapists paid on a per-visit basis from Worksheet A-8-3.[3] Wellmark,[4] the Provider's Intermediary for the period at issue, made an adjustment to include the visits and salaries of these employees on this worksheet and to subject the compensation paid to such employees to the SEGs.[5] Accordingly, the Intermediary disallowed $45,230 for FYE 6/30/95 and $71,026 for FYE 6/30/96.

ISSUE 1: PARTIES' CONTENTIONS:

The Intermediary cites Provider Reimbursement Manual (P.R.M.) §1403 and the regulation at 42 C.F.R. §413.9(c)(2) as support that therapists paid on a fee-for-service basis are subject to the SEGs and that costs should not exceed what a prudent and cost conscious buyer would pay. The Intermediary argues that the fact that the Provider's costs exceeded the SEGs proves that the costs are unreasonable. Moreover, the Administrator's decision in SNI Home Care v. Blue Cross and Blue Shield Association/Cahaba Government Benefit Administrators, 2003-D11, (2/13/03), supports the Intermediary's position.

The Provider argues that the Intermediary erroneously applied the SEGs. Consistent with the Eighth Circuit's decision in In Home Health v. Shalala, 188 F.3d 1043 (8th Cir. 1999), the SEGs apply only to outside contractors, as opposed to employees. The statute at 42 U.S.C. §1395(x)(v)(5)(A) and the regulation at 42 C.F.R. §413.106 make distinctions

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[2] Pursuant to an employment agreement, the Provider withheld the employee therapists' share of Federal Insurance Contributions Act (FICA) and Medicare taxes and paid the employer's share of these taxes. It also paid for the therapists' worker's compensation insurance and provided other benefits, including participation in the Provider's pension plan.

[3] Intermediary Exhibit 1.

[4] Wellmark, Inc. subsequently was replaced by Cahaba Government Benefit Administrators.

[5] See Intermediary Exhibit 3 (Case No. 98-1725, FYE 6/30/95) and Intermediary Exhibit 4 (Case No. 99-2325, FYE 6/30/96).

between services provided under an arrangement from those provided under an employment relationship.

The Provider noted also that the Eighth Circuit's decision in In Home Health dismissed the Secretary's reliance on P.R.M. §1403 by holding that manual provisions are non-binding interpretive rules not subject to Administrative Procedure Act rule-making requirements. Also, the Medicare program's refusal to pay reasonable costs for employee compensation violates the proscription against cross–subsidization.[6]

ISSUE 1: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Intermediary improperly adjusted the Provider's cost report by applying the SEGs for therapy services provided "under arrangement" by outside contractors to the wages paid to the Provider's employee therapists. The Intermediary does not dispute that the therapists were employees of the Provider, but maintains that according to Medicare program instructions, the application of the guidelines is appropriate based on P.R.M. §1403, which states in part:

> [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 and the decisions of numerous courts that have heard this legal dispute. The Board finds compelling the rationale expressed against the application of physical therapy guidelines to in-house physical therapy staff by the U.S. District Court in In Home Health, Inc. v. Shalala, 97-2598 (D. Minn. June 16, 1998). The Court states in part:

> . . . the Act clearly states that physical therapy services performed "under an arrangement" do not include services performed by a physical therapist in an employment relationship with the provider. 42 U.S.C. §1395x(v)(5)(A) reads:
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> > Where physical therapy services . . . are furnished under an 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

[6] See 42 U.S.C. §1395x(v)(1)(A)(i); 42 C.F.R. §§413.5(a) and 413.9(a); P.R.M. §2102.1.

> 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 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.

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

The Board also finds that the SEGs should not be used in place of a prudent buyer analysis. In order to apply the prudent buyer principle, the Intermediary is required to determine whether a provider's costs are "substantially out of line" by comparing those costs to costs incurred by other similarly situated providers. 42 C.F.R. §413.9(c)(2). In the instant case, the Intermediary did not perform a prudent buyer analysis, but attempted to use the SEGs as the basis for the prudent buyer analysis. The Board finds that the use of the SEGs is not a substitute for the analysis required by the regulation.

ISSUE 2: FACTUAL BACKGROUND:

The Provider is related to Potomac Home Support (PHS).[7] The Provider and PHS shared a number of expenses, such as telephones, telephone lines, computer and computer lines, parking, equipment and insurance. These expenses were allocated between the entities based upon a statistical formula.

During the relevant period, the Provider had a line-of-credit agreement with NationsBank, N.A. for $200,000.[8] This agreement was later renewed.[9] This line-of-

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[7] See Provider's July 2, 2004 Brief at footnote 5. The Provider states "the Provider and PHS were separate sister companies under the common ownership and control of a joint venture of Sibley and Suburban Hospital. Prior to February 1998, PHS was a subsidiary of the Provider, although the Provider and PHS were (and still are) bona fide separate organizations."

[8] Provider Exhibit 50 (December 16, 1997 Promissory Note).

[9] Provider Exhibit 51 (December 16, 1998 Line of Credit with Automatic Renewal Feature)

credit superseded an earlier line of credit of $100,000 with NationsBank.[10] PHS was the guarantor of the loans.[11]

For FYE 6/30/99, the Provider reported and claimed interest expense of $17,637 related to the line-of-credit. The Intermediary treated the interest expense as "shared costs" between the Provider and PHS. As such, a portion of the expenses was allocated to PHS and treated as non reimbursable.[12]

It is undisputed that the loan proceeds were used to cover cash flow deficiencies in the Provider's operating cash account, that the Provider's revenues did not cover its cash expenses, and that the account was not used to pay PHS's day-to-day direct expenses.

ISSUE 2: PARTIES' CONTENTIONS

The Intermediary argues that while it initially treated the interest expense as a shared expense, the entire interest amount of $17,637 is not allowable because it was not incurred solely for the Provider.[13] The Intermediary argues that PHS did not replenish or repay the operating account of the Provider; therefore, paying the shared expenses from the Provider's operating account contributed to the Provider's cash flow shortage. As the shortfall was directly created by the Provider paying non-Medicare expenses of its sister company, the amount is unallowable pursuant to 42 C.F.R. §413.153 and P.R.M. §202.

The Provider contends that the Intermediary erred in allocating loan interest to PHS on the assumption that PHS did not repay the Provider for its portion of shared expenses. PHS was billed and paid its share of expenses to the Provider. The Provider notes that PHS derived no benefit from having the Provider pay the shared expense and subsequently reimbursing the Provider for those payments.

ISSUE 2: FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

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[10] Provider Exhibit 52 (April 25, 1997 Promissory Note)

[11] Provider Exhibit 53 (April 25, 1997 Continuing and Conditional Guaranty) and Provider Exhibit 54 (Certificate of Corporate Resolutions); Intermediary Exhibit 2, p 13.

[12] Provider Exhibit 55 (September 25, 2001 NPR, audit adjustment report, and workpapers).

[13] While the Intermediary's original adjustment treated the interest expenses as "shared costs," the Intermediary now argues that the interest was not allowable because the loan was unnecessary. Additionally, in its May 2, 2005 Addendum to the Revised Position Paper, the Intermediary contends that either disallowing the interest or leaving the interest as a pooled expense would produce a similar reimbursement effect.

The Intermediary's position is that the interest expense on the working capital loan is not allowable because the interest was not incurred solely for the Provider and was not "necessary" in accordance with 42 C.F.R. 413.153(a). This position is based on the Intermediary's underlying premise that PHS did not replenish or repay the operating account of the Provider; therefore, paying the shared expenses out of the Provider's operating account helped create or exacerbate a cash flow shortage on a dollar-for-dollar basis.

The Board finds that the underlying premise on which the Intermediary bases its position is inaccurate. The record reflects that PHS promptly paid the Provider for its share of the common expenses. The Provider explains:

> Under general ledger account #19230 (allocations to PHS–pooled costs), Potomac tracked the amount that PHS owed it for shared expenses on a monthly basis. Each month, Potomac recorded a receivable for the allocated (shared) expenses to PHS. Each month, through the cash receipts process, Potomac also recorded payments from PHS for those allocated (shared) expenses. In other words, in all cases where Potomac paid PHS's shared expenses, Potomac was properly and promptly reimbursed by PHS for PHS's share of those expenses.
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> This process occurred pursuant to a budget, using predetermined amounts. PHS's estimated portion of shared expenses was calculated and then allocated on a monthly basis. Potomac recorded the monthly receivable from PHS and then utilized this as an invoice to process payment from PHS for its portion of the shared expenses.[14]

The Board finds that PHS derived no benefit from having the Provider pay the shared expenses and subsequently reimbursing the Provider for the payments. The shared costs were a budgeted item, and PHS made monthly payments of its shared costs regardless of when those costs were actually paid. Accordingly, PHS did not receive the benefit of a "float" or a deferred payment. In addition, as the Provider was indebted to PHS, there was no need for PHS to borrow funds from the Provider or to have the Provider pay its expenses. Moreover, when the Intermediary conducted its "necessity of borrowing test," it disregarded an inter-company payment of $333,796 due from the Provider to PHS on the basis that "payment of liability can be postponed."[15] The Board, however, finds no evidence to support the Intermediary's belief that such payment could be postponed.

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[14] Provider May 27, 2005 Addendum to Provider's Hearing on the Record Submission on Working Capital Loan Interest. See supporting Provider Exhibit 57 (Account History, FYE 6/30/99) and Provider Exhibits 58- 60 (Cash Receipt Logs, October 1998 through December 1998).

[15] Intermediary Exhibit 2 at page 17.

DECISION AND ORDER:

ISSUE 1: The Intermediary improperly applied the SEGs to the Provider's employed physical therapists who were paid on a fee-for-service basis. The Intermediary's adjustments are reversed.

ISSUE 2: The Board finds that the interest is allowable and should not be treated as a shared expense. The Intermediary's adjustment is improper and should be reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: September 27, 2005

Suzanne Cochran
Chairperson