PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D51

PROVIDER -In Home Health, Inc.
Minnetonka, Minnesota

Provider No. Various

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, Blue Cross and Blue Shield of Iowa, Blue Cross and Blue Shield of South Carolina, Blue Cross and Blue Shield of Illinois

DATE OF HEARING-
May 13, 1997

Cost Reporting Period Ended - September 30, 1992 and September 30, 1993

CASE NO. 95-2407G

INDEX

ISSUE:

Whether the physical therapy salary equivalent guidelines as issued and applied to the Providers are arbitrary, capricious and/or not in accordance with 42 C.F.R. § 413.106 or other law?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

In Home Health, Inc. is a publicly-held Minnesota corporation in Minnetonka, Minnesota. Its sole business is to provide home health care services, including physical therapy services. It does business in Minnesota and 13 other states through various branch offices which are classified under 22 provider numbers. Five of its branch offices, each with a different provider number, are involved in this appeal ("Providers"). Four regional home health intermediaries are involved in this case including Blue Cross of California, Blue Cross and Blue Shield of Iowa, Blue Cross and Blue Shield of South Carolina and Blue Cross and Blue Shield of Illinois ("Intermediaries"). On their fiscal years ended ("FYE") 1992 cost reports and the FYE 1993 cost report for one Provider, the Providers self-disallowed[2] the amount by which their physical therapy visit costs, provided by outside suppliers, exceeded the amount published by the Health Care Financing Administration ("HCFA") in the physical therapy salary equivalency guidelines ("guidelines"). The Providers separately and timely filed appeals to each Notice of Program Reimbursement for all six cost reports at issue to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835-.1841 and have met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in dispute is approximately $253,000.

In Section 251 of Public Law 92-603, codified at 42 U.S.C. § 1395x(v)(5)(A), Congress authorized the Secretary to establish limits on reimbursement for physical therapy services. It provides in relevant part that:

> [w]here physical therapy services . . . are furnished under an arrangement with a provider of services . . . the amount included in any payment to such provider . . . shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider . . .) to the person performing them if they had been in an employment relationship with such provider . . .

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[1] There is no dispute that the Intermediary properly applied the guidelines in question to the Providers' cost reports. Tr. at 7-8 and 11-17.

[2] The Intermediaries initially raised a jurisdictional objection to the Providers' appeal because the physical therapy costs were not claimed on the cost report. The Intermediaries subsequently determined that these costs were properly self-disallowed and withdrew their objection. See Tr. at 11.

> plus the cost of such other expenses (including a reasonable allowance for travel time and other reasonable types of expenses related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

42 U.S.C. § 1395x(v)(5)(A).

In 1975, the Secretary promulgated the regulation at 42 C.F.R. § 413.106, entitled "Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements." The regulation requires that HCFA determine guideline amounts equal to the sum of (1) the prevailing hourly salary rate based on the 75th percentile of salary ranges paid providers in the geographic area, (2) a fringe benefit factor to take into account fringes generally received by employee therapists and (3) an expense factor to take into account the expenses an individual not working as an employee might incur in furnishing such services under arrangement. See 42 C.F.R. § 413.106(b)(1), (2) and (3). The regulation and manual provide that exceptions to the guidelines may be granted by the Intermediary. 42 C.F.R. § 413.106(f) and HCFA Pub. 15-1 § 1414.2.

In February of 1975, the Secretary issued guidelines to be effective April 1, 1975. The Secretary revised the guidelines nearly every year until 1983.[3] Since 1983, there have been no updates. The only adjustment to the guideline amount has been a .6 percent increase for each month for inflation, which was established in the last guidelines that were published. This is a non-compounded amount based on pre-1983 inflation data.

In 1997, HCFA issued revised guidelines which substantially increased the guideline amounts from those permitted under the 1983 guidelines adjusted by the non-compounded inflation factor. There were increases in all three categories: the 75th percentile, the fringe amount, and for expenses. The 1997 guidelines also changed the inflation adjustment from non-compounding to compounding.

The Providers initially requested that the Board grant it expedited judicial review based upon previous cases which held that the guidelines had the force of regulations and were not subject to Board review. The Board rejected the Providers' request and the Providers appealed this decision to court. As a result of a request for admissions, the Secretary indicated that the Board did have jurisdiction to determine if the guidelines were issued in accordance with the regulations.[4]

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[3] See Providers Exhibit 39-1 and 39-2.

[4] See Providers Exhibit 13.

None of the Providers sought an exception to the guidelines under the provisions of the regulation and manual.

The Providers were represented by Jonathan M. Bye, Esquire, of Lindquist & Vennum P.L.L.P and Charles F. Mackelvie, Esquire, of MacKelvie & Associates, P.C. The Intermediaries were represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that the guidelines are contrary to law, arbitrary and capricious and thus, are invalid. The Providers also contend that their physical therapy costs were reasonable and that the disallowances due to the application of the salary equivalency guidelines should be reversed, and that the full amount of their physical therapy costs should be allowed.

The Providers contend that the guidelines are invalid because the statute and regulation implicitly and explicitly require that the guidelines be determined on a periodic basis and they have not been determined since 1983. The Providers point out that guidelines used in this case for the 75th percentile of salary ranges paid by providers to physical therapists working full-time in an employment relationship were last determined in 1983 using 1981 data.[5] The fringe benefit factor was last determined in 1983 based on 1980 data.[6] The expense factor was last determined in 1981 based on 1974 and 1981 data.[7] The Providers therefore claim that these guidelines are contrary to 42 C.F.R. § 413.106, which explicitly states that the guideline amount "is determined on a periodic basis." Moreover, both the regulation and 42 U.S.C. § 1395x(v)(5)(A) implicitly require the use of current data in that they both require that the limit be equal to the salary and additional costs which would reasonably have been paid if the services had been performed in an employment relationship. The Providers claim that the only rational way to determine what would have been paid if the services were performed by an employee is to look at current salary data, not at what was paid 10 to 15 years ago. In addition, the Providers note that the regulation's use of the term "prevailing salary" also requires that the 75th percentile of salary ranges paid be determined from current data because "prevailing" means "generally current."[8] Accordingly, the Providers argue that

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5 See Providers Exhibit 39-2.

6 Id.

7 Id.

8 See Webster's Third New International Dictionary of the English Language Unabridged.

under the plain meaning of 42 C.F.R. § 413.106 and 42 U.S.C. § 1395x(v)(5)(A), the guidelines are invalid because they have not been redetermined since 1983.[9]

The Providers also claim that even if periodic determinations were not required, the guidelines are arbitrary, capricious and contrary to law because they do not represent, as required by the regulation, the 75th percentile of salary ranges paid plus reasonable fringe benefit and expense factors. The Providers argue that this is due to flaws in the data used in 1983 and the failure to properly update the guidelines. With respect to the salary component of the guidelines, the Providers note that it is based on 1981 Bureau of Labor Statistics hospital survey data which is 16 years old.[10] The Providers contend that this data is fundamentally flawed for several reasons. First, compared to the period in dispute here, the data is more than 10 years out of date. It is simply arbitrary and capricious to believe that salary information more than 10 years old is reflective of the current market. Testimony from a Board-recognized expert in the area of compensation evaluation and analysis indicated that using data that is 10 or more years old is totally inappropriate.[11] Second, the 1981 data did not include data on physical therapists employed by home health companies.[12] The statute, at 42 U.S.C. § 1395x(v)(5)(A), requires that the guidelines equal what would reasonably have been paid to the therapist had the therapist been "in an employment relationship with such provider." Accordingly, determining the guidelines to be applied to home health providers without any reference to what home health providers pay is contrary to law. Moreover, the Providers claim that this is not just a technical violation. Because physical therapists who work in the home setting work alone, they generally must have a higher level of experience, knowledge, and responsibility than do hospital-based physical therapists. Therefore, they generally have a higher pay structure than hospital-based physical therapists.[13] In connection with announcing the new guidelines, HCFA acknowledged the fact that therapy compensation

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9 The Providers distinguish the statute and regulation in this case from the RCE cases referred to by the Intermediaries, See Tr. at 19, noting that nothing in the statute or regulation relevant to those cases specifically requires periodic determinations or that the limits be based on any "prevailing" rates. See e.g., County of Los Angeles Department of Health Services v. Shalala, No. CV 95-0163 (C.D. Cal. Dec. 13, 1995) affirming the Board's majority opinion in Los Angeles County RCE Group Appeal v. Blue Cross and Blue Shield Association, PRRB Dec. No. 95-D12, December 9, 1994, Medicare & Medicaid Guide (CCH) ¶ 42983 (upholding application of the RCE limits over the provider's argument that they should have been updated annually).

10 See Providers Exhibit 39.

11 Tr. at 57-58.

12 See Providers Exhibit 39.

13 Tr. at 119-121.

is dependent on where the therapist works, stating that, "therapy wage levels are primarily determined in occupational labor markets, not industry labor markets". 62 F.R. at 14851, 14854 (March 28, 1997).[14] Accordingly, the Providers maintain that excluding home care physical therapist salary information from the data arbitrarily and capriciously skewed the salary component of the guidelines downward.

According to the Providers, a third flaw with respect to the salary component of the guidelines is that it is based on data from only 22 major metropolitan statistical areas ("MSAs"). For states with multiple surveyed MSAs, the average of the reported salaries was used. For states with no surveyed MSAs, the average of surrounding states was used. Thus, the data did not consider market differences within a single state or even between some adjoining states.[15] For example, all locations within Arizona, California and Nevada share one rate under the guidelines, even though these states, and areas within these states, have very different market conditions for physical therapy salaries. In connection with the new proposed guidelines, HCFA itself commented on the "major shortcomings" of this approach. 62 F.R. 14851, 14859 (March 28, 1997).[16] As a result, in connection with the new guidelines, HCFA determined the guidelines for 318 different locations. Id.

With respect to the expense factor component of the guidelines, the Providers note that it is expressed in terms of a percentage (24.1 percent) of the prevailing hourly rate and that it is based on data which, compared to the period in dispute here, is nearly 20 years old. The Provider presented a summary of some of the reasons why the expense factor, based on 1974 data, significantly understates the current market.[17] For example, it significantly understates the costs of rent, malpractice insurance and telephone service, and does not include any costs for such things as copy machines, fax machines and computers, which either did not exist or were not in wide use in 1974. According to the Providers, HCFA recognizes that the 24.1 percent expense factor is inaccurate. In connection with calculating the new proposed guidelines, HCFA determined that expenses currently represent 44.3 percent of prevailing salary, nearly double the amount used in the guidelines applied to the Providers.[18]

With respect to the fringe benefit component, the Providers note that it is also expressed in terms of a percentage of the prevailing hourly rate (16.5 percent), based on 1980 American

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[14] See Providers Exhibit 2-7.

[15] See Providers Exhibit 39.

[16] See Providers Exhibit 2-15.

[17] Providers Exhibit 17-3. See also Tr. at 121-123.

[18] Tr. at 123.

Hospital Association statistics.[19] The Providers argue that use of this old data is arbitrary and capricious. Expert testimony indicated that "[f]ringe benefits have [under] gone massive changes since the 1974 to 1980 era when these numbers were created."[20] In particular, it was pointed out that the costs of health insurance have skyrocketed, and that statutory benefits, such as Social Security, have increased as a percentage of pay.[21] According to the Providers, HCFA recognizes that fringe benefits have increased as a percentage of pay, and now calculates them to be 24.3 percent of salary.[22]

The Providers also argue that the harm caused by the initial flaws in establishing the guidelines in 1983 have been exacerbated by the failure to update them properly. While the Intermediaries argue that the guidelines have been updated since 1983, pointing to the .6 percent per month non-compounded inflation adjustment, the Providers claim this argument is flawed for several reasons. First, the regulation specifically requires that the salary, fringe benefit and expense components of the guidelines be "determined" on a periodic basis, not that they just be updated by an inflation factor. 42 C.F.R. § 413.106(b)(3). Second, the .6 percent per month is based on pre-1983 inflation data and is thus, in and of itself, seriously out of date.[23] Third, the .6 percent per month is an additive factor and thus, unlike inflation, is not compounded. The Providers presented figures which illustrates that this creates a straight line factor that basically trends toward zero.[24] The Provider also presented figures that illustrates the difference in the increase in the guideline amounts as opposed to the increase in the section 223 physical therapy cost limits, which do reflect the actual market increases in agency costs.[25] There was testimony that indicated that "to use data from 1980 or before and multiply that by [a] non-compounded factor just doesn't even give you the ball park figure of where you need to be. The degree of error is enormous."[26] The Providers note that, once again, even HCFA acknowledges the problems with the straight line, non-compound index, stating, "[t]he effect of using the additive adjustment factor rather than the multiplicative factor is that the additive factor gets progressively smaller in percentage terms each year." 62

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19 See Providers Exhibit 39.

20 Tr. at 74.

21 Tr. at 74-75.

22 Tr. at 123.

23 See Providers Exhibit 39.

24 Providers Exhibit 24.

25 See Providers Exhibit 29 and Tr. at 125-127.

26 Tr. at 74.

F.R. at 14851, 14870 (March 28, 1997).[27] Accordingly, even HCFA proposes to use a multiplicative factor in future years. Id.

The Providers also presented the report of Findley Davies, Inc. and testimony to demonstrate that the guidelines do not represent the 75th percentile of salary ranges paid plus reasonable fringe benefit and expense factors.[28] For the six provider years in dispute, Findley Davies applied the same methodology used by HCFA to determine the guideline amounts, but, instead used more current market data, geographic differentials, fringe benefit factors and office overhead factors.[29]

Based on this analysis, Findley Davies concluded that the salary equivalency guidelines which were applied to the Providers' physical therapy costs do not represent the 75th percentile of salary ranges paid by providers in the geographical area to physical therapists working full-time in an employment relationship. Second, it concluded that the Providers' costs were not substantially out of line with other providers in the area and, in fact, that their costs were low within the marketplace.

The Providers also maintain that HCFA's recent proposed guidelines demonstrate that the guidelines do not represent the 75th percentile of salary ranges paid plus reasonable fringe benefit and expense factors. The Providers note that HCFA issued new proposed physical therapy salary equivalency guidelines, 62 F.R. 14851 (March 28, 1997), which indicates that HCFA has determined that the guidelines should be using more current data. They are based on 1995 data and on 1991 data that was escalated by HCFA to 1995, using various indexes. This data was then escalated by HCFA to April 1997, using price indexes. The Providers note that there are "new" guideline amounts for the locations in dispute here.[30]

The Providers presented a detailed comparison of the "old" guideline amounts to the new proposed guideline amounts for the locations in dispute in the instant case.[31] For example, HCFA calculates that as of April, 1997, the "old" guideline amounts for the areas in dispute are from 61.2 percent to 12 percent understated. The Providers contend that this alone indicates the invalidity of the "old" guidelines. Moreover, the Providers presented an analysis of what the guideline amounts would be using the current HCFA data de-escalated to the

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27 See Providers Exhibit 2-34 through 2-35.

28 Providers Exhibit 33 and Tr. at 55-97.

29 The detailed calculations of the Findley Davies analysis are contained in its appendix at Providers Exhibit 33-15 through 20.

30 See Providers Exhibit 21.

31 See Providers Exhibit 40.

years in dispute (FYE 10/1/91 and 10/1/92).[32] In doing so, the Providers used the exact data and techniques utilized by HCFA in escalating data in developing the "new" guidelines.[33] The Providers indicate that the results of their analysis show:

- The "new" de-escalated guidelines for all areas in dispute are substantially higher than the "old" guidelines.

- The amounts paid by the Providers in all areas in dispute were substantially lower than the "new" de-escalated guidelines.

Accordingly, the Providers claim that HCFA's own data demonstrates that the guidelines do not represent the market as required by the regulation and that the Providers' costs were reasonable. Although the Intermediaries claim that HCFA's determination of the guideline amount based on 1991 and 1995 data is irrelevant,[34] the Providers disagree. They claim it is far more relevant to use 1991 and 1995 data, adjusted to the 1992 and 1993 periods in dispute using known inflation factors, than to use 1974, 1980 and 1981 data adjusted for ten years on a non-compounded basis using pre-1983 inflation data. In fact, the Providers note that HCFA itself has recognized the validity of determining the guidelines and then applying them retroactively, having done so on three occasions.[35]

Finally, the Providers point out that once the guidelines are determined to be invalid, the only remaining issue is whether their physical therapy costs were reasonable. See HCFA Pub. 15-1 § 1403 (in the absence of valid therapy guidelines, the cost of those services "will continue to be evaluated under the Medicare program's requirement that only reasonable costs be reimbursed"). Thus, in the absence of valid physical therapy guidelines, the only basis for disallowing the Providers' physical therapy costs would be if they were not reasonable, i.e., if they were "substantially out of line with other institutions in the same area". See 42 C.F.R. § 413.9. The Providers point out, however, that the Intermediaries have not even claimed that their costs "were substantially out of line" much less presented any analysis in that regard.[36] In contrast, the Providers presented unrefuted evidence that their costs were reasonable and appropriate in the marketplace. Specifically, the Providers maintain that the Findley Davies

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32 Id.

33 Id. Also see Tr. at 143-5. In addition, Providers Exhibit 44 sets forth the results of de-escalation using seven other relevant price indexes. All show amounts being paid below the re-calculated guideline amount.

34 Tr. at 19.

35 Providers Exhibit 39-2.

36 Tr. at 41.

report and HCFA's new proposed guidelines demonstrate that their costs were not only reasonable, but were low within the market.

The Providers note that the undisputed evidence is that their physical therapy costs were reasonable. Thus, they claim that the only reason their costs were disallowed is because HCFA failed to update the guidelines for nearly 15 years. The Providers maintain that HCFA's failure is inexcusable and contrary to law and that they should not be forced to bear the costs of HCFA's negligent and unlawful inaction. Accordingly, the Providers request that the disallowances due to application of the physical therapy salary equivalency guidelines be reversed and that the full amount of their physical therapy costs be allowed.

In summary, the Providers' contend that they do not have to apply for an exception under the regulations because they are not claiming the guidelines are inappropriate for them because of some unique circumstances or special labor condition. Instead, they are challenging the validity of the guidelines, including the methods used to develop them and update them. These flaws effect the Providers without regard to their geographic location or unique circumstances. The regulation is not challenged, rather the Secretary's failure to comply with her regulations.

INTERMEDIARIES' CONTENTIONS:

The Intermediaries indicate that they properly applied the guidelines as they existed in the fiscal years at issue. The Intermediaries contend that the Providers did not seek relief under the "exception process" provided for under the regulation and manual provisions at 42 C.F.R. § 413.106(f) and HCFA Pub. 15-1 § 1414.2, and have therefore failed to exhaust their administrative remedies. The Intermediaries contend that the guidelines were properly promulgated and are not invalid because they were not perfect when issued, or they needed to be subsequently revised.

The Intermediaries note that the Providers acknowledge that they do not dispute their calculation of the amount for physical therapy services. Despite their withdrawal of their objection to the Providers appealing costs not claimed on the cost report,[37] the Intermediaries still maintain that the Providers have not complied with the exception request process under the regulation and manual and therefore the Board should dismiss the appeal. The Intermediaries refer to the following language in the regulation:

> [e]xception because of unique circumstances or special labor market conditions. An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services

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[37] Tr. at 11.

established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area.

42 C.F.R. § 413.106(f)(2).

Thus, the Providers have failed to exhaust their administrative remedies under the regulation and manual provision.

The Intermediaries also contend that the regulations were properly promulgated. The Intermediary notes that the Secretary has authority to issue regulations under 42 U.S.C. § 1395hh and that they were properly published on May 28, 1974, 39 Fed. Reg. 18467. The requisite 60 day comment period was allowed, and the final regulations were published on February 7, 1975, 40 Fed. Reg. 5760. Consistent with the intent of Congress, the guidelines were established on an area wide basis and were set at the 75th percentile of the salary ranges in each area. Also consistent with congressional intent, the data used to formulate the guidelines was from the Bureau of Labor statistics and were computed on an hourly basis. The guidelines were also properly updated in the federal register on February 19, 1976, 41 Fed. Reg. 7542, and amended on August 30, 1976, 41 Fed. Reg. 36531-4.

The Intermediaries claim that the guidelines do not have to be perfect. In recognition of the needs of administering a nationwide program, Congress specifically authorized the use of estimates in connection with establishing limits on reimbursement. The U.S. Supreme Court has upheld that in the context of social welfare programs; a classification will not be voided just because it "is not made with mathematical nicety, or because in practiced it results in some inequality." Dandrige v. Williams, 397 U.S. 471, 485 (1970) ("Dandrige"), quoting Lindsey v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1991). If there is some reasonable basis for the rule, it must be upheld. Concerns with the guidelines have been raised and rejected in Physical Therapy Group Appeal v. Blue Cross Association/Various Blue Cross Plans, HCFA Administrator, April 27, 1979, Medicare and Medicaid Guide (CCH) ¶ 29,703 ("PT Group Appeal").

The Intermediaries state that the Providers' arguments regarding the validity of the regulation or its method of promulgation are without merit. The Intermediaries indicate the Board should dismiss the case because the Providers have not exhausted their administrative remedies.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395x(v)(5)(A)	-	Services Under Arrangement

2. Regulations - 42 C.F.R.:

§ 413.9	-	Cost Related to Patient Care
§ 413.106 et seq.	-	Reasonable Cost of Physical and Other Therapy Services furnished Under Arrangements

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 1403	-	Guideline Application
§ 1414 et seq.	-	Claimed Costs in Excess of Guidelines

4. Cases:

Dandrige v. Williams, 397 U.S. 471, 485 (1970).

Mercy Hospital of Laredo v. Heckler, 777 F.2d 1028 (5th Cir. 1985).

Physical Therapy Group Appeal v. Blue Cross Association/Various Blue Cross Plans, HCFA Administrator, April 27, 1979, Medicare and Medicaid Guide (CCH) ¶ 29,703 County of Los Angeles Department of Health Services v. Shalala, No. CV 95-0163 (C.D. Cal. Dec. 13, 1995).

5. Other:

39 Fed. Reg. 18467 (May 28, 1974).

40 Fed. Reg. 5760 (February 7, 1975).

41 Fed. Reg. 7542 (February 19, 1976).

41 Fed. Reg. 36531 (August 30, 1976).

62 Fed. Reg. 14851 (March 28, 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing brief, finds and concludes as follows:

The Board finds that the physical therapy guidelines were properly promulgated and that the Intermediaries properly used them to limit the Providers' physical therapy costs. The Board also finds that the Providers did not exhaust their administrative remedies by applying for an exception under the regulation and manual provisions and, thus, are not entitled to relief.

The regulations provide that the guidelines are to be established at 75 percent of the prevailing physical therapy rate in an area and that they are to be periodically updated. 42 C.F.R. § 413.106. The Board finds that the guidelines were properly promulgated under the regulations. The guidelines used reasonable data sources, albeit not perfect, to set the guideline rates. The Board agrees with the Intermediaries' argument that the guidelines need not be perfect to be sustained, and notes that the guidelines have been previously upheld. See Dandrige, and PT Group Appeal, supra. Since the regulations do not specify that the guidelines must be updated annually, the Board finds that the initial annual rates during the earlier period of the guidelines, followed by monthly updates for inflation after 1983, are minimally compliant.

In addition, the Board notes that the regulations and manual provisions provide an opportunity for providers, through an exception process, to demonstrate that the guideline amounts are not reasonable. 42 C.F.R. § 413.106(f)(2) and HCFA Pub. 15-1 § 1414. The manual specifically allows an exception for unique circumstances or special market conditions which the Board finds applicable to the present situation. It states that "the provider must submit evidence enabling the intermediary to establish that the going rate in the area for this particular type of service is higher than the guidelines limit and that such services are unavailable at the guidelines amounts." HCFA Pub. 15-1 § 414.2. The manual further states that the provider must submit evidence that the going rate in its area is higher than the guideline limit and that it has, after reasonable attempts, been unable to obtain services at the guideline amounts. Id. The Board acknowledges that the Providers presented ample evidence that the rates may have been understated and, therefore, unreasonable. The Board notes, however, that the Providers did not present evidence in the record that they were unable to obtain physical therapy services in their areas at or below the rates set in the guidelines. Had the Providers sought an exception, the Intermediaries would have been required to determine the rates that other providers in the area generally have to pay and whether an exception was warranted. Id. The Board notes that in Mercy Hospital of Laredo v. Heckler, 777 F.2d 1028 (5th Cir. 1985), the court upheld the necessity of applying for an exception to the guidelines in order to exhaust one's administrative remedies and seek relief. The Board finds that the Providers should have, but did not, utilize the exception process to challenge the reasonableness of the rates in the guidelines and therefore their request for relief cannot be granted.

In summary, the Board finds that the guidelines were properly promulgated, correctly used by the Intermediaries to limit the Providers' physical therapy costs, and that the Providers cannot seek relief because they did not exhaust their administrative remedies under the exception procedure.

DECISION AND ORDER:

The Intermediaries adjustments limiting the Providers' physical therapy costs to the guidelines amounts were proper. The Intermediaries adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: May 20, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Schedule of-Providers in Group [Part 1]

Group Name: In Home Health, Inc.-Physical Therapy
Representative: Charles F. MacKelvie, Esq.
Case No: 95-2407G
Date Prepared : 9/11/95

Issue: Whether In Home should be paid the difference between the amount allowed under the Salary Equivalency Guidelines (the "Guidelines") as applied to outside contractor physical therapist and the amount that should have been allowed if the Guidelines had been properly promulgated and updated pursuant to 42 C.F.R. §413.106(d)(1-6).

Schedule Entry	Prov. No.	Prov. Name	Cost Rep. Period	Inter.	Exh. A Date of Final Determination.
1	03-7076	In Home Health	9/30/92	BC-CA	9/10/93
2	03-7076	In Home Health	9/30/93	SC-CA	9/23/94
3	05-7132	In Home Health	9/30/92	BC-IA	9/28/94
4	05-7605	In Home Health	9/30/92	BC-CA	9/10/93
5	14-7200	In Home Health	9/30/93	BC-SC	12/20/94
6	36-7472	In Home Health	9/30/92	BC-IL	8/25/94

Schedule of-Providers in Group [Part 2]

Schedule Entry	Exh. B Date of Hearing Request	# of Days	Date Req. to Add Additional Issue	Exh. D Audit Adjustment	Approx. Reimub Impact	Org. Case # (if any
1	3/2/94	173	9/8/95	n/a	12,312	94-2067
2	3/6/95	164	9/8/95	n/a	4,391	95-1253
3	3/17/95	170	9/8/95	n/a	71,986	95-1933
4	3/2/94	173	9/8/95	n/a	1,753	94-2066
5	4/17/95	118	9/8/95	n/a	17,658	95-1999
6	2/3/95	162	9/8/95	n/a	9,985	95-0925