# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

ON THE RECORD
2002-D21

**PROVIDER** –
HomeAid, Inc. of Cumberland Plateau

Provider No. 44-7442

**vs.**

**INTERMEDIARY** -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrator

**DATE OF HEARING**
March 12, 2002

Cost Reporting Period Ended -
December 31, 1992

**CASE NO.**: 96-1820

**INDEX**

ISSUE:

Was the Intermediary's adjustment to the Provider's cost report to remove legal fees proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

HomeAid, Inc. of Cumberland Plateau (the "Provider") is a freestanding home health agency certified and licensed to do business in Cumberland, Dekalb, Fentress, Jackson, Overton, Pickett, Putnam and White counties in Tennessee. On its fiscal year ended ("FYE") December 31, 1992 cost report, the Provider claimed costs associated with attorney fees. Blue Cross and Blue Shield of South Carolina, known now as Palmetto Government Benefits Administrators (the "Intermediary") disallowed the attorney fees. The Provider filed a timely appeal and has met the jurisdictional requirements set forth in 42 C.F.R. § 405.1835-.1841. The Medicare reimbursement at issue in this appeal is approximately $35,000.

The legal fees that were disallowed relate to two separate matters. The first matter, with total expenses of $35,572, concerned eight employees who left employment with the Provider to commence employment with competing home health agencies. These former employees attempted to solicit patients away from the Provider to their new places of employment. The Provider then brought legal action against the former employees and other home health agencies. The Provider sought a permanent injunction against the defendants to make them cease contacting their patients. The Intermediary's audit adjustment disallowed all legal fees associated with this lawsuit, indicating that these fees were not related to patient care but rather an attempt by the Provider to eliminate future competition, thus preserving the patient base of the Provider.

The second lawsuit, with total expenses of $202, relates to a legal action brought by the Provider against the former Administrator. The Provider terminated the Administrator for breach of certain provisions in her employment agreement with the Provider. In a separate settlement agreement with the Administrator, she agreed to work for another home health agency but not to solicit the patients of the Provider. The Provider contends that the former Administrator breached the settlement agreement and attempted to solicit patients of the Provider to utilize the services of her new employer. The Provider then brought legal action against the former Administrator for breach of confidentiality and for the breach of the non-solicitation provision of the settlement agreement. The Provider also states that it brought suit against the former Administrator for breach of certain agreements and sought damages from the former Administrator for filing false and fraudulent medical reimbursement claims. The Provider did not indicate whether it was able to recover any damages, as was allowed under the employment agreement.[1]

[1] See Intermediary Position Paper at 3.

The Provider was represented by W. Marshall Pearson, Esquire. The Intermediary was represented by Donna Tapucu, CPA, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider indicates that the Intermediary disallowed $35,572 related to litigation with several former employees and the two companies with which they subsequently became employed, claiming the legal fees were not properly documented.[2] The Provider submitted a written summary of the case prepared by the Provider's in-house legal counsel as requested by the Intermediary, and discussed the issue with the Intermediary during the course of the field audit. The Provider strongly contends this case was related to patient care and notes that the case has subsequently been resolved in a manner which supports the Provider's position that the issues involved in the litigation were, in fact, related to patient care.

Several of the Provider's former employees ("defendants") left in the fall of 1992. The defendants left to commence employment with two other home health agencies. The defendants, in conjunction with the other home health agencies, contacted patients of the Provider in an effort to disrupt their plan of care with the Provider and to persuade them to utilize these competing home health agencies.

Upon learning of this activity, the Provider sought and was granted a temporary injunction by the Chancery Court in Putnam County, Tennessee, to stop the defendants from interfering with the Provider's care of its patients. Specifically, the Temporary Injunction restrained the defendants from:

(A) Soliciting the patients who were home health patients of HomeAid as of September 18, 1992, either directly or indirectly, for the purpose of inducing those patients to terminate the use of the services of HomeAid and begin using the services of Golden Rule Home Care.

(b) Utilizing, divulging or disclosing any confidential and/or proprietary information concerning any individual who was a patient of HomeAid as of September 18, 1992, to any third party, or utilizing any such information for any of the defendants' benefit.

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[2] See Intermediary adjustment No. 12, Provider Exhibit 1.

Order, March 22, 1993.[3]

In addition to the injunctive relief sought in the Complaint filed by the Provider, the Provider filed several claims against the defendants for interfering with the care of the Provider's patients, including breach of duty of loyalty and misappropriation of confidential patient-care related information.

One of the defendants had been the Director of Professional Services at the Provider and, along with the other defendants, was a vital component of patient care delivery. The lawsuit filed against the defendants was brought for the specific purpose of avoiding and curtailing the disruption of the Provider's operation and delivery of patient care. A lawsuit was the only possible alternative in attempting to resolve this situation. The Provider asserts that it had no choice but to file this litigation in order to put a stop to the attempted disruption of its delivery of patient care.

As a result of this litigation, the Provider obtained a permanent injunction which prevented any future interference by the defendants with the Provider's care of its patients.

It is the Provider's position that the litigation was directly related to patient care. This fact is borne out by the Chancellor's statements in his final ruling in connection with this litigation:

> The court further finds that, although Plantiff has no proprietary right in the names of patients, there is evidence that this information has been used in a way that has caused confusion and would continue to cause confusion, such that a strong likelihood exist that Plantiff would suffer harm and injury.

[3] Provider Exhibit 2.

Final Order, May 11, 1994 (emphasis added).[4]

The Provider contends that the confusion that the court refers to is the confusion of its elderly patients. Thus, legal fees incurred by the Provider related to the litigation were the result of protecting the interests of the Provider's patients and their ability to receive uninterrupted patient care services so as not to impede the quality of care. The Provider's intent in filing the litigation was to prohibit the former employees from visiting the patients in question because the patients, as determined by the court, were upset and confused by the visits, and the visits constituted an immediate threat to the continuation of patient care.

While the Intermediary apparently believed that the purpose of the litigation was to eliminate future competition, this argument is clearly refuted by the court's decision in that litigation. The defendant employers were allowed to advertise and provide information which reaches the general public, including the patients at risk in this matter. The defendants were simply restrained from personal visits or conversations with patients on record with the Provider as of September 19, 1992; once these patients were discharged from the Provider, the court's Order did not apply. Thus, the legal expenses incurred did not relate to elimination of future competition or non-compete issues; they were strictly related to protecting specific patients under the Provider's care at a specific point in time, based solely upon the impending threat to patient care. The Provider contends, and indicates that the court agreed, that the interference by former employees related to the continuing care of the Provider's patients. Moreover, the court found that because the visits caused confusion among these ill, elderly patients, patient care was threatened.

The Provider believes that the litigation against the defendants and the associated costs were thus reasonable and necessary expenses related directly to the Provider's delivery of care to its patients and that these costs are reimbursable under current Medicare reimbursement regulations.

The Provider notes that the Intermediary also disallowed $202 of legal expenses related to a lawsuit filed against the Provider's former Administrator. The Intermediary disallowed these costs based on its conclusion that the Provider's former Administrator was terminated from her position for cause.

The Provider believes that the Intermediary's conclusion is unreasonable based on the fact of the particular situation surrounding her termination. The Provider further contends that it was the former Administrator's breach of certain provisions of her Employment Agreement that made the litigation necessary.

The Provider contends that its former Administrator was a vital component of patient care

[4] Provider Exhibit 3.

delivery. The Provider terminated her in June 1991 for breach of obligations under her Employment Agreement to maintain liability insurance coverage for her automobile and for falsification of an "Auto Policy Declaration" document concerning her liability coverage. The former Administrator then engaged an attorney due to a dispute between the parties as to their respective obligations to one another and as to the confidentiality of patient medical information obtained while she was an employee of the Provider.

In order to (1) settle the disputes between the parties; (2) effectuate a smooth transition for the Provider and avoid any disruption to the Provider's patients and employees and the Provider's operation and delivery of patient care; and (3) avoid litigation costs which would necessarily be incurred in order to enforce the Administrator's obligations to the Provider and its patients, the Provider, in good faith, and with a view towards minimizing costs, entered into a Release and Settlement Agreement with the Administrator. The Provider paid the Administrator severance benefits and agreed to let her work for another home health agency, provided that she did not proceed to solicit the Provider's patients and employees and thereby disrupt the Provider's delivery of patient care.

However, almost immediately after the Administrator signed the Release and Settlement Agreement, she began using confidential patient and employee information in order to solicit both the Provider's patients and employees on behalf of her new employer. This situation was disruptive to the Provider's delivery of patient care. Additionally, it was subsequently determined that the Administrator had filed false and fraudulent medical reimbursement claims with the Provider's insurance carrier.

A lawsuit was the only alternative in attempting to resolve these problems after the Provider's attempts to discuss them with the Administrator failed. Accordingly, the Provider filed suit against the Administrator for breach of the confidentiality and non-solicitation provisions of the Release and Settlement Agreement, as well as other provisions of her Employment Agreement, and for filing false and fraudulent medical reimbursement claims with the Provider's insurance carrier. The Administrator subsequently filed a counterclaim in the lawsuit against the Provider.

In this litigation, the Provider sought a monetary judgment against the Administrator for its damages, including a judgment for the severance benefits previously paid to the Administrator (to which she was not entitled after breaching the terms of the severance agreement), as well as injunctive relief to prevent the Administrator from violating the terms of the Release and Settlement Agreement as well as her Employment Agreement. In addition, the Provider sought damages for the filing of the false and fraudulent medical reimbursement claims.

The Provider believes that the litigation costs were reasonable and necessary expenses related directly to the Provider's delivery of care to its patients as required by CMS Pub. 15-1 §§ 2102.1 and 2102.2, and were incurred in an attempt to minimize future expenses related to the Administrator.

For the foregoing reasons, the Provider respectfully requests that the legal expenses related to

adjustment No. 12 to the Provider's cost report be included in allowable costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary understands the rationale for initiating lawsuits to preserve business interests; however, it is the responsibility of the Intermediary to determine that costs incurred while in the ordinary course of business are also related to patient care and reflect a common practice in the industry. There are numerous examples of costs incurred by providers in the ordinary course of business, but these costs may not be reimbursable by Medicare. Such is the case with the disallowed legal expenses of $35,774. This legal expense claimed by the Provider was incurred to preserve the patient utilization base of the Provider and to also preserve its market share in its geographic location.

This activity is not related to patient care nor is it considered to be necessary. This is supported by 42 U.S.C. § 1395a, which states that:

> [a]ny individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

(emphasis added).

This is also supported by 42 C.F.R. §§ 413.9, 413.20 and 413.24 and CMS Pub. 15-1 §§ 2102.2, 2102.3, 2103 and 2304. Specifically, CMS Pub. 15-1 § 2102.2, Costs Related to Patient Care, states that:

> [t]hese include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include personnel costs, administrative costs, costs of employee pension plans, normal standby costs, and others. Allowability of costs is subject to the regulations prescribing the treatment of specific items under the Medicare program.

It has always been a longstanding policy of the Medicare program that costs associated with the preservation (or increase) of market share are costs not related to patient care. CMS considers legal expenses such an important issue that specific audit steps are outlined under the Medicare Intermediary Manual, Part 4 ("MIM 13-4"), § 7005, "Exhibits," (Audit Step 6.18). The activity of patient solicitation is outlined under CMS Pub. 15-1 § 2113.2, "Patient Solicitation," which states that:

> [c]osts incurred by a home health agency for personnel performing duties in the

> hospital or SNF which are primarily directed toward patient solicitation are unallowable costs for Medicare reimbursement purposes (see PRM section 2136.ff). Visits made by HHA personnel to patients which have not yet been referred to the HHA (as evidenced by the patient's medical record) in order to persuade the patient to request the HHA's services are considered patient solicitation, as would visits to physicians to obtain referrals. Obtaining referrals by means of a cooperating hospital or SNF employee, or by reviewing patient records to identify potential patients for the HHA, are also considered patient solicitation. The costs of HHA personnel engaged in the activity, and any costs the HHA incurs for meals, entertainment, gifts, etc., given to influence these parties to refer patients to the HHA are unallowable costs.

The legal activities of the Provider are considered by the Intermediary to be a form of patient solicitation, as the Provider attempted to preserve its patient base and to thwart potential competition in its geographical location.

According to the Intermediary's workpaper number 14-5, 3/6,[5] the Provider had legal counsel available at the home office level and had the opportunity to utilize their particular services. Instead, the Provider decided to utilize the services of outside counsel.

The Intermediary, in its workpaper number 14-5, 6/6,[6] discusses that the legal costs incurred by the Provider in this situation are not common costs within the home health industry. In addition, the legal costs were not related to the production of services for beneficiaries, the costs were not helpful in developing and maintaining the Provider's patient care facilities and the costs were not necessary nor proper. The Intermediary's position is also supported by Gulf Coast Home Health Group Appeal-Legal Fees v. Aetna Life Insurance Co., PRRB Dec. No. 90-D64, September 26, 1990, Medicare and Medicaid Guide ¶ 38,873, CMS Administrator declined review, November 5, 1990, aff'd, Gulf Coast Home Health Services, (D.C.C. 1992) Medicare and Medicaid Guide ¶ 40,133 and Florida Medical Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Florida, PRRB Dec. No. 93-D48, June 23, 1993, Medicare and Medicaid Guide ¶ 41,573, aff'd, CMS Administrator, September 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,790, aff'd, Florida Medical Center, Inc., (S.D. FL 1996) Medicare and Medicaid Guide (CCH) ¶ 44,690.[7] Even though the issues were different for each of the above cited cases, the underlying expense related to legal fees was associated with preserving the provider's patient base and the determinations were that the legal costs were not related to patient care.

The Provider did not furnish sufficient information and documentation, pursuant to 42 C.F.R. §§ 413.20 and 413.24, and CMS Pub 15-1 §§ 2300, 2304ff and 2402.2. These regulations and

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[5] Intermediary Exhibit 1.

[6] Intermediary Exhibit 2.

[7] Intermediary Exhibits 3 and 4.

instructions explicitly require the Provider to maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited, and in sufficient detail to accomplish the intended purpose.

The Provider did not prepare its position paper as it pertains to this issue in accordance with 42 C.F.R. § 405.1853 and CMS Pub. 15-1 § 2921.5. It did not state adequate facts and contentions or furnish any documentary evidence to support its appeal of this issue.

The Provider did not demonstrate with any evidence that the adjustment made by the Intermediary during the audit was inaccurate, erroneous or unacceptable for cost reporting purposes. It also did not demonstrate that the issue concerning the Intermediary's disallowance of legal expenses would require a correction of the related adjustments.

The referenced Medicare program regulations and instructions support the Intermediary's determinations and adjustments. The Board should therefore uphold the Intermediary's argument pursuant to 42 U.S.C. § 1395oo, 42 C.F.R. § 405.1867 and CMS Pub. 15-1 § 2924.6.

The statute at 42 U.S.C. § 1395oo states as follows:

> (e) The Board shall have full power to make rules and establish procedures not inconsistent with the provisions of this title or regulations of the Secretary....

The regulation at 42 C.F.R. § 405.1867 states as follows:

> In exercising its authority to conduct the hearings . . , the Board must comply with all the provisions of Title XVIII of the Act and regulations issued hereunder, as well as [CMS] rulings issued under the authority of the Administrator of the [CMS] . . .

CMS Pub 15-1 § 2924.6, contains a similar provision.

Under the circumstances, the intermediary does not have a basis to revise its determinations or adjustments. The Intermediary requests that the Board affirm its position.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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| § 1395a | - | Free Choice by Patient Guaranteed |
| § 1395oo | - | Provider Reimbursement Review Board |

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

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| § 405.1835-.1841 | - | Board Jurisdiction |
| § 405.1853 | - | Prehearing discovery and Other Proceedings Prior to the Board Hearing |
| § 405.1867 | - | Sources of Board's Authority |
| § 413.9 | - | Costs Related to Patient Care |
| § 413.20 | - | Financial Data and Reports |
| § 413.24 | - | Adequate Cost Data and Cost Finding |

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

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| § 2102.1 | - | Reasonable Costs |
| § 2102.2 | - | Costs Related to Patient Care |
| § 2102.3 | - | Costs Not Related to Patient Care |
| § 2103 | - | Prudent Buyer |
| § 2113.2 | - | Patient Solicitation |
| § 2300 | - | Adequate Cost Data and Cost Finding: Principle |
| § 2304ff | - | Adequacy of Cost Information |
| § 2402.2 | - | Participating Provider |
| § 2921.5 | - | Position Papers |
| § 2924.6 | - | Intermediary Participation |

4. Cases:

Florida Medical Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross and

Blue Shield of Florida, PRRB Dec. No. 93-D48, June 23, 1993, Medicare and Medicaid Guide ¶ 41,573, aff'd, CMS Administrator, September 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,790, aff'd, Florida Medical Center, Inc., (S.D. FL 1996) Medicare and Medicaid Guide (CCH) ¶ 44,690

Gulf Coast Home Health Group Appeal-Legal Fees v. Aetna Life Insurance Co., PRRB Dec. No. 90-D64, September 26, 1990, Medicare and Medicaid Guide ¶ 38,873, CMS Administrator declined review, November 5, 1990, aff'd, Gulf Coast Home Health Services, (D.C.C. 1992) Medicare and Medicaid Guide ¶ 40,133

5. Other:

Medicare Intermediary Manual, Part 4 (MIM 13-4) § 7005, "Exhibits"

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts and parties' contentions, finds and concludes as follows:

The Board finds that the record does not contain sufficient documentation to support the Provider's claim that its attorney fees were reasonable or related to patient care. To the contrary, the Board finds that the evidence in the record supports the Intermediary's assertion that the purpose of the litigation was to preserve the Provider's patient base.

The Board notes that the Provider insists that the litigation for which it seeks reimbursement of attorney fees was required to protect its patients from interference with care. The Board observes that the only documentation furnished in support of the claim is two court orders, one issued upon application for a temporary injunction and a Final Order.[8] Absent from the Provider's submission, however, are litigation papers that would more clearly establish precisely what issues were involved and whether the fees claimed were reasonable. For example, the Provider did not furnish the pleadings, including the amended pleadings which the court noted were filed.[9] The Provider also did not furnish the Board with any of the "various motions of the

[8] See Provider Exhibits 2 and 3.

[9] See Provider Exhibit 2.

parties" referenced in the Order or any other evidentiary materials that might have shed light on the issues.[10] The Provider also did not submit any of the attorney fee bills. The Board notes that the Intermediary submitted a "summary" of the litigation apparently prepared by a contracted management company's in-house attorney; however, only a portion was submitted, and even that failed to identify what materials the summarizing attorney relied on.[11]

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[10] Id.

[11] See Intermediary Exhibit 2.

The Board finds that the two court orders submitted do not establish that the litigation was related to patient care. Rather the court orders substantiate the Intermediary's conclusion that the litigation was instituted to protect the Provider's market share from competition. The injunctive relief granted all relates to solicitation of patients.[12] The Board further notes that the Providers' claim that the court found that the defendants' actions had caused the patients to be confused and harmed[13] is not supported by the document. While the court does recite that patient names had been used in such a way as to cause confusion, the court only found that the "Plaintiff" would suffer harm and injury.[14] Without more evidence, the Board cannot make the assumption that the Provider's assertions of what was involved are correct.

In summary, the Board finds insufficient documentation to support the Provider's claim that the legal fees were reasonable or related to patient care.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's cost report to remove legal fees was correct. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: May 29, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

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12 See Provider Exhibit 2, 2(a) and (b).

13 See Provider Position Paper at 5 purporting to quote for the court Order in Provider Exhibit 3.

14 See Provider Exhibit 3, No. 2.