PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2004-D3

PROVIDER –
Tri-County Home Health Care and
Services, Inc.
Columbia, South Carolina

Provider No. 42-7010

vs.

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

DATE OF HEARING -
August 20, 2003

Cost Reporting Period Ended
September 30, 1996

CASE NO. 99-3323

INDEX

ISSUES:

1. Was the Intermediary's adjustment to Board of Directors fees proper?
2. Was the Intermediary's adjustment to legal and professional fees proper?
3. Was the Intermediary's adjustment to key employee compensation proper?
4. Was the Intermediary's adjustment to routine and non-routine supply costs proper?

FACTS:

Tri-County Home Health Care and Services, Inc. ("Provider") is a closely held corporation located in Columbia, South Carolina. The Provider is owned and managed by Medical Services of America, Inc., a home office which is located in Lexington, South Carolina. The Provider is serviced by Palmetto Government Benefits Administrators ("Intermediary").

The Provider was dissatisfied with the Intermediary's adjustments and requested a hearing before the Provider Reimbursement Review Board ("Board"). The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R §§405.1835-.1841. The amount of Medicare reimbursement is approximately $221,123.

The Provider was represented at the record hearing by J. Scott McDearmon, Esq., of Grant, Kovalinka & Harrison. The Intermediary was represented by Bernard M. Talbert, Esq., the Blue Cross and Blue Shield Association.

ISSUE 1- DIRECTORS' FEES

FACTS:

The Intermediary denied $41,183 in fees paid to members of the Provider's Board of Directors for the fiscal year ended September 30, 1996. The Intermediary determined, based on prior audit results, that Board members' (directors) reimbursement should be limited to $100 per hour for actual time spent in the Board meetings.

PROVIDER'S CONTENTIONS:

The Provider points out that the Medicare regulations at 42 C.F.R § 484.14(b) require that each Medicare certified provider maintain a governing body which assumes legal authority and responsibility for the operation of the agency. The governing body must appoint an administrator, arrange for professional consulting input from qualified/medical personnel, ensure qualified personnel and adequate staff education and evaluation, ensure the accuracy of public information materials and activities and implement an effective budgeting and accounting system. The Provider argues that those duties cannot be fully discharged in the two-hour Board meetings.

The Provider contends that the Intermediary failed to compare its Board of Directors' fees with fees paid by similarly situated providers. The Provider maintains that it

provided the Intermediary with a 1997/1998 compensation study by Marks & Wyatt Data Services entitled "Compensation for Outside Directors Providing Regular Board Services." The survey indicates that the lowest 25% of directors received $19, 750 per year while the outside directors received $27,857. Even with a modest discount for inflation over a one-and-one half to two-year period between the year ending September 30, 1996 and the median date of the survey results, the $6,000 payments to most Board members would constitute approximately 30% of the payments to the lowest quartile of directors in the survey.

The Provider argues that the individuals who serve as outside members of a Board of Directors assume potential liabilities in serving as directors. In the absence of some financial incentive, no Medicare provider would attract competent directors. Given the extensive duties placed upon the Board by 42 C.F.R § 484.14 (b), the Intermediary's allowance of $675 per director - approximately 3-1/2% of the amount the average director in the lowest paid quartile earned - is unreasonable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the amount of Directors' fees paid by the Provider was not reasonable. The amount of Directors' fees as calculated from the Provider's records indicated that the average Board meeting lasted approximately two hours and translated into an average hourly rate of from $25 to $1,000 per hour. The Intermediary determined that a reasonable fee was $100 per hour.

The Intermediary contends that the Provider did not furnish any additional documentation to justify the excessive Directors' fees. The Provider failed to furnish evidence supporting the value of Directors' incidental activities or whether Board members actively participated in the operations of the Provider or merely attended the Board meetings. The Provider did not provide evidence as to the experience and backgrounds of the Board members and the value each brought to the Provider. The Provider did not provide evidence to determine if the Board members actively participated in budget meetings or merely approved the budget.

The Intermediary points out that in Dyna Care Home Health, Inc. v. Blue Cross and Blue Shield Association/Health Care Service Corporation, Inc., PRRB Dec. No. 98-D68, June 25, 1998, upheld U.S. DC, Northern District of Illinois No. 98 c 5122, July 6, 1999 the Board stated:

> "The secretary's disallowance of compensation for the HHA's non-shareholder directors was not arbitrary and capricious. The HHA did not provide sufficient documentation to determine the reasonableness of the directors' compensation."

In that case the provider submitted one set of minutes for a 1991 meeting and one set for a 1992 meeting. The intermediary's allowance of an annual $100 nominal fee for each non-employee board member was affirmed.

The Intermediary contends that it is the responsibility of the Provider to furnish documentation in accordance with 42 C.F.R. § 413.9, §413.20 and §413.24, as well as section 2304 of the Provider Reimbursement Manual, so that the Intermediary can properly determine the allowability of costs and apportionment methods used by the Provider. Since the Provider did not provide adequate documentation to support its arguments, the Intermediary utilized the best information available from the Provider's books and records to determine the proper amount of Medicare reimbursement

ISSUE 2-PROFESSIONAL FEES

FACTS:

The Intermediary disallowed all or a portion of the fees of the Human Resources Consultant, the Pharmacy Consultant and the Consultant for Continuity of Care and Other Patient Issues. The three Consultants were all members of the Provider's Board of Directors.

Human Resources Consultant

On the individual invoices, the billings only state that they are for "Human Resources Consultants" and that the payments relate to "services for the month of…" The Intermediary determined that the invoices did not sufficiently describe the type of services rendered and denied all of the fees due to lack of documentation.

Pharmacy Consultant:

The Intermediary disallowed a portion of the fees paid to the Pharmacy Consultant and reduced the amount of cost claimed based on the time spent by the Pharmacy Consultant.

Continuity of Care Consultant:

The Intermediary disallowed the cost of the Continuity of Care Consultant due to a lack of documentation and a duplication of services.

PROVIDER'S CONTENTIONS:

HUMAN RESOURCES CONSULTANT

The Provider contends that its use of a Human Resources Consultant is no different than any provider's subscription to an advisory service on human resources, such as those published by Commerce Clearing House or the Bureau of National Affairs. Individual human resource consultants who charge even a modest hourly fee would have cost the Provider several times the amount it paid to the consulting firm.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the cost of the Human Resource Consultant is not an allowable Medicare cost, as this type of expenditure is not a common practice or expenditure for a home health agency. Also, as the Provider has a Director of Human Resources, the services furnished by this consultant are duplicative. The Intermediary also points out that very little documentation was provided to substantiate the duties of the consultant. The only evidence reviewed by the Intermediary was the checks and invoices paid by the Provider, and the invoices did not state what services the invoice covered. In addition, the Intermediary contends that the information described by the Provider can easily be obtained, without cost, by contacting the federal or State Department of labor.

PHARMACY CONSULTANT

PROVIDER'S CONTENTIONS:

The Provider argues that the cost of the Pharmacist consultant is an allowable cost for a home health agency. The Provider contends that the Medicare regulation at 42 C.F.R. § 484.55(c) states:

> The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

The Provider contends that the auditors arbitrarily assigned an amount of $50 per hour and fifteen minutes to review a patient record. The Provider argues that the Intermediary's statement that the Medical-Director could have performed the patient review is ludicrous, as the Director would not have had time to deal with a fraction of the patients' medical charts in addition to his other duties and private practice.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the Provider made payments to the Pharmacy Consultant in the amount of $34,400. The Pharmacy Consultant is also a member of the Provider's Board of Directors. The Pharmacy Consultant's job was to review the types of medications that patients were currently receiving. The Intermediary contends that this is also the function of the Medical Director and possibly the Director of Nursing. This is also the function of the individual patient's physician. The Intermediary further contends that quite a few patients were not prescribed medications and several patients were infants that who were also not prescribed medications.

The Intermediary argues that the amount paid to the Pharmacy Consultant was excessive and limited the rate to $50 per hour. The resulting disallowance reduced the allowable costs by $26,688.

CONTINUITY OF CARE CONSULTANT

PROVIDER'S CONTENTIONS:

The Provider argues that $45,900 was a reasonable cost for its Continuity of Care project which was designed to improve provider-patient relations and ensure continuity of care for all of the Provider's patients. The cost of the project clearly falls within the scope of the Medicare regulation at 42 C.F.R. § 413.9. Therefore, the Provider contends that this cost is allowable, as it is related to patient care.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the amount paid to the Continuity of Care Consultant was not proper. It is also noted that this consultant is a member of the Provider's Board of Directors.

A portion of the amount paid to this consultant was duplicative of the services paid to another consultant and, therefore, not allowable. The Intermediary argues that the intent of the project entitled "continuity of care" was actually to increase Durable Medical Equipment (DME) sales and was not related to patient care. The analysis furnished shows that it is merely an analysis and compilation of DME used by individual patients. The cost paid to the consultant of $1,350 per day worked was excessive. The same data could have been obtained by the Provider's clerical staff for a lesser amount. In addition, the Intermediary contends that the Provider did not have sufficient documentation to verify the costs claimed.

ISSUE 3- KEY EMPLOYEE COMPENSATION

FACTS:

The Medicare regulation at 42 C.F.R. §413.102, defines compensation as including salary and amounts paid for managerial, administrative, professional and other services, as well as amounts paid by the provider for the personal benefit of the proprietor and deferred compensation. The regulation also requires that the compensation be reasonable and necessary.

The Intermediary reduced the compensation of the Director of Human Resources by $13,366. The Intermediary determined reasonable compensation with the use of the Michigan Physical Therapy Provider/Owner Survey (Michigan Survey). Medicare law and regulations require the reimbursement of a reasonable allowance of compensation for Medicare providers' owners and administrative personnel, provided that the services are actually performed and are necessary functions of the facility.

PROVIDER'S CONTENTIONS:

The Provider points out that the Medicare regulation defining reasonableness requires that the compensation "be such an amount as would ordinarily be paid for comparable services by comparable institutions." The Provider contends that the Intermediary determined that the compensation was excessive solely on the basis of the Michigan Survey. Nowhere in the auditors' workpapers are any references to any entity similarly situated to the Provider. The auditors failed to compare the amount of salary in contention with the salaries paid by any other provider in the Columbia, South Carolina or southeastern United States areas.

The Provider points out that in Midwest Speech & Hearing Associates, Inc. v. Aetna Life & Casualty Company, PRRB Dec. No. 85-D39, April 23, 1985, the Board found that the intermediary's use of the respiratory and physical therapy guidelines as a basis for determining reasonable compensation to the owner/director of a speech pathology provider was not proper. Similarly, in Total Care, Inc. (Charlotte, North Carolina), v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of South Carolina, PRRB Dec. No. 91-D65, August 22, 1991, the Board reversed the intermediary's prior disallowance of a home health agency's owner's compensation due to the intermediary's failure to obtain valid comparisons.

The Provider points out that the Board has recently rejected the Michigan Survey as a legitimate methodology for determining allowable owners' compensation. The Board determined that the Michigan Survey "does not produce results that are representative of the providers' organization and therefore, cannot serve as the basis for cost disallowance." Call-a-Nurse v. Blue Cross and Blue shield of Iowa and Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D50, May 20, 1998. The Board also found that there was no assurance that the compensation data contained in the Michigan Survey was representative of the compensation levels paid by health care organizations in the provider's geographical area.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its use of the Michigan Survey in determining reasonableness of the compensation paid to the Director of Human Resources was in accordance with the program regulations and instructions.

The Intermediary contends that the Director of Human Resources only spent approximately 86% of her time performing duties for the Provider. According to the IRS Form W-2, her total annual salary was $92,523.81, which appears excessive for a home agency the size of the Provider. The Intermediary argues that the $4,978.83 relating to health insurance premiums paid for the benefit of the employee should also be included in the determination of reasonable compensation, as it is a fringe benefit.

The Intermediary contends that its reliance on the Michigan Survey was because the Program regulations and instructions do not give a precise measurement regarding the

concept of reasonableness. The Intermediary's use of the latest survey, prepared by the health care industry, should be recognized as another acceptable basis on which to ensure the reasonableness of owner's compensation.

ISSUE 4 - SUPPLY COSTS

FACTS:

The Provider purchased $276,182 in medical supplies from Medi Home Health Agency, Inc. who is affiliated with the Provider's consultant, Medical Services of America, Inc. The Intermediary contended that Medi Home was a related organization to the Provider. And reduced the Provider's claimed routine and non-routine medical supply costs to the actual costs of the related organization, Medi Home. The related organization principle, found at 42 C.F.R. § 413.17, allows reimbursement of costs paid by a provider to a related organization for services or supplies, but limits those to the actual cost paid by the supplying organization, with the additional requirement that the cost not exceed the price of comparable services or supplies that could be purchased elsewhere.

An exception exists, however, to the related organization principle. If the provider satisfies four requirements, charges by the supplier related to the provider for the subject services or supplies are allowable as costs. The factors are as follows:

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization;

(iii) The services, facilities or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

42 C.F.R. §413.17(d).

PROVIDER'S CONTENTIONS:

The Provider argues that it met the exception to the related party principle in that Medi Home's total sales to the Provider during the fiscal period at issue were $276,182, while its sales to other related parties were $1,633,848. Sales to all parties were $24,943,369.

The Provider maintains that the Intermediary erred when it concluded that the Provider failed to prove that a substantial amount of business was conducted with other outside organizations. The Provider points out that Medi Home's medical supplies sales were co-mingled with its Durable Medical Equipment (DME) sales. Only 1.1% of Medi Home's sales were to the Provider. Overall, only 6.55% of Medi Home's sales were to related parties. Where a supplying organization conducts over 93% of its business with unrelated parties, that organization does a substantial part of its business activity with those unrelated parties.

The Provider maintains that the Intermediary erred in its calculation of the cost of the medical supplies Medi Home sold to the Provider. If an adjustment were necessary, the amount of the adjustment should have been limited to $39,687, the actual profit to Medi Home of 16.78%.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider was unable to separate Medi Home's sales between DME and medical supplies. The Intermediary determined that the related organization was unable to document that a substantial part of its business activity was transacted with parties other than the Provider for the sale of medical supplies that were not DME. The Intermediary points out that the Provider did not demonstrate with any evidence that the reduction of related organization charges to cost was inaccurate or unacceptable for cost reporting purposes.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, parties' contentions and evidence submitted, finds and concludes the following:

DIRECTORS' FEES

The Intermediary properly adjusted the Directors' fees.

The Board finds that the Provider's Board of Directors were also "key officers of the home office," a related organization and that some of the board members were paid consultants to the Provider. The Board finds that the study of Directors' salaries, which the Provider presented in its contentions, was not persuasive of reasonable director fees. There was no indication of what data went into the study or that the figures produced by the study were representative of the Provider. The study did not indicate the size or area of the population but only stated that it was a "Health Care Study." It did not include the

types of facilities, the scope of services performed or the size and area of the facilities contained in the study. In addition, there was no evidence as to whether the study participants were publicly traded or closely held facilities.

The Board finds that the Provider's argument that the directors did more than attend meetings as justification of their high fees was not supported by the evidence. Absent sufficient documentation to support the high fees paid to the directors, the Board concludes that the Intermediary's adjustment of the fees to $100 per hour was reasonable.

LEGAL AND PROFESSIONAL FEES

HUMAN RESOURCES CONSULTANT

The Intermediary improperly adjusted the fees paid to the Human Resources Consultant.

The Board finds that, although the documentation is sketchy and sparse, a subscription service is not unreasonable in a labor-intensive business, and this information is extremely valuable in such a business. The Board finds that the cost of the service was not excessive nor was it duplicative. Therefore, the Board concludes that the Intermediary's adjustment should be reversed.

PHARMACY CONSULTANT

The Intermediary properly adjusted the pharmacy consultant's fee.

The Board finds that the services of the pharmacy consultant was an appropriate service for the Provider. However, the Board finds that $200 per hour paid to the Pharmacy Consultant was excessive. The Provider did not challenge the Intermediary's review nor produce any evidence to contradict the Intermediary's adjustment to $50 per hour. The Board finds that the pharmacist's review of patients' charts concerning proper medication is also the responsibility of the Director of Nursing and the patient's own physician. Therefore, although the pharmacy consultant's services may have been appropriate, the amount paid to the consultant was excessive and was properly reduced to a reasonable amount.

CONTINUITY OF CARE CONSULTANT

The Intermediary properly adjusted the Continuity of Care Consultant's fee.

The Board finds that the invoices submitted by the consultant contained only the name of the consultant and the amount of the fee. The invoices did not describe the type of services or the time that the services were performed.

The Board finds that the evidence presented by the Provider was sparse and indicated that the information obtained by the consultant was used for marketing purposes. The Board finds that the work performed by the consultant appears to have been a compilation of

data from the files of the Provider. No particular expertise was required in obtaining or compiling the data. Therefore, the Board concludes that the payment to the consultant of $1,350 per day was excessive. The Board further concludes that the total amount paid to the consultant was not necessary and that the Intermediary's disallowance was proper.

KEY EMPLOYEE COMPENSATION

The Intermediary improperly adjusted the key employee compensation.

The Board finds that there was no evidence that the compensation was paid to an owner of the facility. Therefore, the comparison made by the Intermediary is not applicable.

The Board finds that the Michigan Study is a study of the salaries of Physical Therapy company owners. There was no evidence that the study represents a home health agency administrator. Therefore, the Board concludes that the Intermediary's adjustment of the Director of Human Services' salary was improper.

SUPPLY COSTS

The Intermediary properly adjusted the Provider's supply costs.

The Board finds that the Provider failed to support its position that it is entitled to an exception to the related organization principles enunciated at 42 C.F.R. § 413.17(d). The related party vendor's sales of routine and non-routine supplies were commingled with its sales of DME in such a way that it was impossible to determine the amounts of supply sales to unrelated parties. Furthermore, what evidence there is in the records is not supported by any form of source data. Finally, the Provider failed to provide copies of the supplying organization's financial statements and sales journal that may have supported its claimed mark-up percentages and the amount of supply sales to unrelated parties.

The Board finds that the Provider's contention that it is entitled to an exception to the related organization regulation is without merit.

DECISION AND ORDER:

Directors' Fees

The Intermediary properly adjusted the fees of the members of the Provider's Board of Directors. The Intermediary's adjustment is affirmed.

Legal and Professional Fees

Human Resources Consultant

The Intermediary's adjustment of the cost of the Human Resources Consultant was not proper. The Intermediary's adjustment is reversed.

Pharmacy Consultant

The Intermediary's adjustment of the cost of the Pharmacy Consultant was proper. The Intermediary's adjustment is affirmed.

Continuity of Care Consultant

The Intermediary's adjustment of the cost of the Continuity of Care Consultant was proper. The Intermediary's adjustment is affirmed.

Key Employee Compensation

The Intermediary's adjustment to the salary of the Director of Human Resources was not proper. The Intermediary's adjustment is reversed.

Supply Costs

The Intermediary's adjustment to the Provider's supply cost was proper. The Intermediary's adjustment is affirmed

BOARD MEMBERS PARTICIPATING

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

FOR THE BOARD

Date: November 21, 2003

Suzanne Cochran
Chairman