PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D24

PROVIDER –
Visiting Nurse Association of North Central Indiana, Inc.

Provider No. 15-7046

vs.

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

DATE OF HEARING -
February 10, 2004

Cost Reporting Period Ended
December 31, 1995

CASE NO. 98-0815

INDEX

ISSUE:

Was the Intermediary's decision to deny the Provider's request for an exception to Medicare's salary equivalency guidelines for physical therapy services furnished under arrangement proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Visiting Nurse Association of North Central Indiana, Inc. (Provider) is a Medicare certified home health agency located in Elwood, Indiana. During its cost reporting period ended December 31, 1995, the Provider furnished physical therapy services to its patients through a variety of therapy contractors.[1] On March 26, 1996, after the close of its December 31, 1995 cost reporting period, the Provider requested an exception to the physical therapy cost limitations relating is contract services for the period beginning January 1, 1995. In its request, the Provider stated that due to its rural location, it was unable to recruit and hire therapists at rates below Medicare's cost limits or salary equivalency guidelines (guidelines).[2] Health Care Service Corporation (Intermediary) reviewed the Provider's exception request and, on May 8, 1996, denied it on the grounds that the Provider had not furnished appropriate evidence to support its claim.[3]

On August 9, 1997, the Intermediary issued a Notice of Program Reimbursement (NPR) reflecting an adjustment to the Provider's physical therapy costs.[4] The adjustment reversed the "protested amount" that the Provider had included in its cost report to show the effect of the guidelines on its otherwise reimbursable costs. On February 4, 1998, the Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is $36,822.

The Provider was represented by L. Alan Whaley and Karen Ann P. Lloyd of Ice Miller Donadio & Ryan. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

BACKGROUND:

The Medicare program reimburses providers for the reasonable costs they incur to furnish physical and other therapy services to Medicare beneficiaries. The program further provides that where such services are provided "under an arrangement" with an outside supplier, the amount recognized as reasonable is limited to:

> an amount equal to the salary which would reasonably have been paid for such services . . . to the person performing them if they

[1] Provider Position Paper at 2 of 15.
[2] Exhibit P-5
[3] Exhibit P-6. Note also Palmetto Government Benefits Administrators is the Provider's current Intermediary.
[4] Exhibit P-8.

> had been performed in an employment relationship with such provider or other organization . . ., plus the costs of such other expenses . . ., incurred by such person, as the Secretary may in regulation determine to be appropriate.

42 U.S.C. §1395x(v)(5)(A).

Implementing regulations at 42 C.F.R. §413.106ff reiterate the statutory requirements and add that the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), will publish guidelines which reflect the equivalency amounts or cost limitations applied to contracted therapy services. The regulations also provide for an exception to the guidelines. In part, the regulations allow an intermediary to grant an exception:

> if a provider demonstrates that the costs for therapy services 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).

The Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) provides additional guidance for providers requesting an exception to the salary equivalency guidelines. In part, the manual states:

> Exception Because of Unique Circumstances or Special Labor Market Conditions.-- An exception may be granted under this section by the intermediary when a provider demonstrates that the costs for therapy or other services established by the guidelines are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area. Exceptions will only be granted in extraordinary circumstances. Before the exception may be granted, the provider must submit appropriate evidence to its intermediary to substantiate its claim. The providers request for an exception, together with substantiating documentation, must be submitted to the intermediary each year, no later than 90 days after the close of the cost reporting period . . .
>
> In order to establish an exception for unique circumstances, the provider must submit evidence to establish that it has some unique method of delivering therapy or other services, which affects its costs, different from the other providers in the area . . .
> In order to substantiate special labor market conditions, 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 guideline limit and that such services are

> unavailable at the guideline amounts . . . . It is the duty of the provider to prove to the satisfaction of the intermediary that it has reasonably exhausted possible sources of this service without success. As a minimum, the provider must submit documentation showing the salary or wage rates it pays its therapists and other health care specialists. The provider must also submit evidence to establish that it has advertised on several occasions in a newspaper having widespread circulation in the area and that it has contacted employment agencies in the area, if available. . . .

HCFA Pub. 15-1 §1414.2.

The manual further explains that an exception will be effective retroactive to the start of the provider's cost reporting period when the evidence indicates the provider sought to obtain less costly therapy services prior to the onset of its cost reporting period. Id.

PROVIDER'S CONTENTIONS:

The Provider contends that it timely submitted convincing evidence documenting the unique circumstances or special labor conditions that required it to obtain physical therapy services from outside contractors at rates exceeding the Medicare guidelines.[5]

The Provider asserts that it submitted evidence to demonstrate that it tried to hire physical therapists by placing ads on several occasions in local newspapers during 1995 and 1996. However, it received no responses to these ads.[6] The Provider even petitioned the Immigration and Naturalization Service for a permit to bring a foreign therapist into the country. However, this petition was denied.[7]

The Provider also contends that it contacted various staffing agencies in an attempt to obtain contract therapy services.[8] However, these agencies refused to lower their rates due to the difficulty in recruiting therapists to serve patients in rural areas. The Provider believes its repeated contacts with these agencies clearly demonstrate its willingness to purchase therapy services from any reliable source.[9]

The Provider avers that the Intermediary failed to comply with HCFA Pub. 15-1 §1414.2, which directs the Intermediary to determine the rates other providers in the area are paying for therapy services. With respect to the instant case, the Provider asserts that the Intermediary presented no evidence that it complied with this requirement. Rather, the Provider itself demonstrated the difficulties other health care providers were encountering in their attempts to hire therapists; even the area hospitals were forced to use contracted therapists. The Provider believes that the Intermediary failed to review its exception request,

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[5] Provider Position Paper at 10 of 15.
[6] Exhibit P-2.
[7] Exhibit P-3
[8] See Provider Position Paper at 2 of 15 for a listing of staffing agencies referenced by the Provider.
[9] Exhibit P-3.

or that it was reviewed in only a perfunctory manner. The Provider notes that the Intermediary also failed to produce any authority supporting its reversal of the subject protested amount or to explain in its NPR why Medicare law and regulations require such an adjustment.[10]

The Provider maintains that it offered sufficient support with its original request to satisfy the requirements of HCFA Pub. 15-1 §1414.2. However, the Provider asserts that even if the Board believes its original request was insufficient, it should consider the additional information submitted into evidence for this appeal.[11] The Provider cites In Home Health, Inc., d/b/a/ Home Health Plus v. Blue Cross Blue Shield Association, PRRB Dec. No. 96-D16, February 27, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,065, rev'd., CMS Administrator, April 29, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,595, (In Home Health), where the Board considered the substance of the provider's request even though it was submitted more than two years late.

The Provider contends that the Intermediary, in its position paper, attempts to cast doubt on the validity or truthfulness of the information the Provider has submitted. In response, the Provider presents the Affidavit of Jessie Westlund, R.N., its Executive Director.[12] In her affidavit, the Director reaffirms the accuracy of the Provider's evidence and contentions, such as the fact that the Provider placed the ads it said it did, that there was no response to the ads, and that the Provider had to pay higher rates to its physical therapists despite efforts to negotiate lower rates.

Finally, the Provider cites Halifax Memorial Hospital v. Blue Cross Blue Shield Association, PRRB Dec. No. 91-D77, September 11, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,626 modif'd, CMS Administrator, November 12, 1991, Medicare & Medicaid Guide (CCH) at 41,381, (Halifax), and explains that the Board and the Administrator found in that case that the provider warranted a special labor market condition exception to the cost guidelines. The Provider notes that the provider in Halifax established even fewer factors to warrant a special labor market condition exception than the Provider has in this appeal.[13] In Halifax, the provider relied primarily, if not exclusively, on a wage survey, while here the Provider has amply documented its extensive efforts to find and retain physical therapists to provide necessary services.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not submit sufficient evidence to substantiate its request for an exception to the therapy guidelines due to unique circumstances or special labor market conditions.[14] The Provider's request consisted of a cover letter dated March 26, 1996 and copies of the contracts it had with outside therapy

[10] Provider Position Paper at 14 of 15.
[11] Supplemental Statement of the Provider.
[12] Id. Exhibit P-11.
[13] Provider Position Paper at 13.
[14] Intermediary Position Paper at 2.

suppliers.[15] The Intermediary asserts that the Provider's request did not comply with HCFA Pub. 15-1 §1414.2, which requires the Provider to submit:

- evidence to establish that it has some unique method of delivering therapy or other services, which affects its costs, different from the other providers in the area;

- evidence enabling the Intermediary to establish that the going rate in the area for this particular type of service is higher than the guideline limit and that such services are unavailable at the guideline amounts;

- adequate documentation showing the salary or wage rates it pays its therapists; and

- evidence to establish that it has advertised on several occasions in a newspaper having widespread circulation in the area and that it has contacted employment agencies in the area, if available.

The Intermediary contends that the Provider's request did not include documentation supporting its advertising efforts or otherwise provide evidence such as rejection letters in support of its attempt to secure physical therapy services at lower rates. The Provider did not detail the total amount claimed on the cost report or offer invoices and cancelled checks as support for amounts paid.

The Intermediary contends that it is the Provider's responsibility to establish that it had exhausted possible sources for obtaining physical therapy services. Since the Provider did not meet this requirement, the Intermediary is not obligated to generate information to affirm or dispute the Provider's position. If the request had been acceptable, the Intermediary would have determined rates that other providers in the area generally paid therapists and compared them to the Provider's amounts.

The Intermediary disagrees with the Provider's reliance upon the decisions rendered in Halifax. In that case, the Board and the Administrator found that the intermediary erred in evaluating the provider's request and that the provider did, in fact, qualify for an exception based upon special labor market conditions. The Intermediary contends that those findings contrast the instant case where the Provider's request did not have sufficient documentation to establish that the Provider qualified for a unique circumstances or special labor market exception.

The Intermediary cites In Home Health in support of its position. The Intermediary explains that, in that case, the CMS Administrator found (on remand from USCD Minn.) that had the Provider's request been timely, it still would not have met the necessary criteria for an exception under 42 C.F.R. §413.106(f)(2). Under this criteria, "the provider must submit evidence enabling the intermediary to establish that the going rate in the area for this

[15] Exhibit I-2.

particular type of service is higher than the guideline limit and that such services are not available at the guideline amounts." In this case, "the Intermediary noted that, in order to support this criteria, the Provider would need documentation to show that offers were made and refused for costs that would fall within the Guidelines."

Finally, the Intermediary contends that a reconsideration of the Provider's request at this time based upon new information is beyond the time limit established by HCFA Pub. 15-1, §1414.2.[16] The Intermediary asserts, however, that even if the request were to be reconsidered it should still be denied. The Intermediary summarizes the documentation submitted in the Provider's position paper as follows:

- Recruitment Advertisements (Exhibit P-2) - The Provider's documentation includes copies of ads faxed to individuals requesting their review and a price to run the ads on January 15 and 16, 1995. The copies do not indicate what publications were contacted, and there is no evidence that the ads were actually placed. In addition, there are copies of ads sent to the Indianapolis Star Classified to be run on May 7th, 8th and 9th, 1995. Again, there is no evidence that the ads were actually placed. Other ads are shown for 1996, but they are not applicable to the subject cost reporting period.

- Filing with the Department of Immigration (Exhibit P-3)- The Provider explains that it went as far as to petition the Immigration and Naturalization Service (INS) for a permit to bring a foreign therapist into the country, but this petition was denied. However, the Provider's exhibit also includes a letter from INS dated June 16, 1994, indicating that the documentation submitted by the Provider "is not sufficient to warrant favorable consideration. . . ."

- Staffing Agency Contracts (Exhibit P-4)- This exhibit includes a summary of the Provider's independent physical therapy contractors during its 1995 and 1996 cost reporting periods. Information on Q Resource, Inc. is only partially complete when compared to the Provider's exception request at Exhibit P-5. The Provider states that it tried to re-negotiate the contract with Q Resources, Inc. but does not provide any evidence to support its statement. Moreover, the Provider does not include support for services rendered by: Reah Tan at $55.00 for 2/20/95 through 5/19/95, Ferdinand Quijano at $57.00 for 8/14/95 through 8/14/95, Reah Tan at $55.00 for 9/18/95 through 12/1/95, Doris Gayosa at $55.00 for 10/17/95 through 1/15/96, and Alvin Guangco at $57.00 for 10/31/95 through 1/15196.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

[16] Intermediary Position Paper at 7.

The Provider requested an exception to the reasonable cost guidelines (limits) that Medicare places on physical therapy services furnished by outside suppliers, i.e., services furnished "under arrangement." In general, the Provider explains that an exception is warranted because it was unable to recruit and hire therapists in its rural location and because it was unable to secure contractor services at rates below the Medicare guideline amounts. Although the Provider submitted its request timely and explained the difficulties it had in obtaining physical therapy services, the Intermediary concluded that the Provider had not furnished substantive evidence to support its claim and denied the Provider's request. Accordingly, the analysis of this case hinges upon the evidentiary requirements established by the Medicare program and placed on the Provider in order to obtain an exception and the Provider's response to those requirements.

Regulations at 42 C.F.R. §413.106 (f)(2) provide general guidance regarding this matter. In part, the regulations state that an exception may be granted "if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or because of special labor market conditions in the area." Id. (Emphasis added).

Program manual instructions at HCFA Pub. 15-1 §1414.2 provide further guidance. With respect to requests based upon "special labor market conditions," which is at issue in this case, the manual requires the Provider to:

- submit its request for an exception, together with substantiating documentation, no later than 90 days after the close of the cost reporting period;

- submit evidence enabling the intermediary to establish that the going rate in the area for this particular type of service is higher than the guideline limit and that such services are unavailable at the guideline amounts;

- prove that it has reasonably exhausted possible sources of this service without success;

- submit documentation showing the salary or wage rates it pays its therapists; and

- submit evidence to establish that it has advertised on several occasions in a newspaper having widespread circulation in the area and that it has contacted employment agencies in the area in order to obtain services.

Regarding these requirements, the record shows that the Provider only furnished copies of its supplier contracts along with its request. However, the Provider later furnished the Board with documentation pertaining to newspaper advertisements and a 1994 filing with the INS in an effort to obtain foreign physical therapists, charts summarizing the Provider's agreements with other providers and physical therapy vendors, and an affidavit signed by the

Provider's Executive Director attesting to the accuracy of the Provider's submissions and contentions.

Upon review, the Board majority concludes that the Provider's documentation does not fulfill the Program's requirements. The Provider furnished no evidence that would enable the Intermediary to establish the going rate for physical therapy services in the Provider's location. The Provider's documentation relating to this requirement consists of copies of the contracts it had with three therapy suppliers. There is simply no assurance that the rates charged by these three vendors are representative of rates that may have been charged by therapy vendors throughout the Provider's thirteen-county service area.

Also, the Provider did not furnish substantive evidence showing it had reasonably exhausted all other sources of therapy services that may have been available. The Provider's key evidence is a chart showing the organizations it had contracted with to obtain therapy services, documentation relating to the Provider's contacts with the INS and certain documentation regarding newspaper advertisements. The Board majority finds the Provider's chart reflecting its three contracts and its documented attempt to hire a therapist through the INS are not, in and of themselves, convincing proof that the Provider had actually identified and contacted all reasonable sources of therapy services. Moreover, the Provider's documentation regarding its newspaper advertising is somewhat indistinct. In lieu of copies of actual ads placed in prominent newspapers, the Provider furnished copies of telecopy transmissions to unidentifiable sources requesting a review and price for running ads. Notably, the Provider furnished no copies of invoices or canceled checks payable to newspapers. And, even though the Provider's Executive Director attested that ads were placed, she could not with certainty identify the specific newspapers that were used.

The Board majority acknowledges the Intermediary's argument that documentation submitted more than 90 days after the close of the Provider's cost reporting period should not be considered in determining whether or not an exception is warranted. However, the Board majority finds the language in HCFA Pub. 15-1 §1414.2, which directs providers to submit their requests within the 90-day period "together with substantiating documentation," to be a general guideline rather than a clear and definitive rule. The manual's language is unlike that used elsewhere in program instructions and regulations that clearly define timing requirements. Accordingly, the Board majority considered all documentation submitted by the Provider in support of its request.

Finally, the Board majority acknowledges the Provider's argument that the Intermediary failed to determine the rates other providers in its area paid for physical therapy services, as it is required to do pursuant to HCFA Pub. 15-1 §1414.2; and that the Intermediary may have failed to review its request or reviewed it in a perfunctory manner. The Board majority finds, however, that this argument is without merit. Had the Provider submitted substantiating evidence regarding its need for an exception, the Intermediary's analysis of rates paid by other providers would have assisted in either approving or denying the request. However, absent such evidence, the Intermediary's analysis would have served little purpose. Clearly, it is not the Intermediary's responsibility to prove the Provider is entitled to an exception.

DECISION AND ORDER:

The Intermediary's decision to deny the Provider's request for an exception to Medicare's salary equivalency guidelines for physical therapy services furnished under arrangement was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq. (Dissenting)
Dr. Gary B. Blodgett (Dissenting)
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, CPA
Anjali Mulchandani

DATE: June 7, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Dissenting opinion of Gary B. Blodgett

I respectfully disagree with the majority opinion in VNA of North Central Indiana, Inc. vs. Blue Cross and Blue Shield of Illinois wherein VNA's request for an exception to its contract physical therapy cost limitations for unique circumstances or special labor market conditions was denied.

VNA had difficulty hiring physical therapists during the period at issue because it served a large thirteen county primarily rural population. Because of a critical shortage of physical therapists, VNA was unable to hire a staff physical therapist and was left with no alternative other than contracting with various staffing agencies to secure physical therapists to provide therapy services for its patients.

The Provider furnished copies of eight newspaper advertisements for physical therapists that it contends had been placed in at least four different newspapers during the period Jan. 13, 1995 through April 17, 1996. (Provider Exhibit P-2). In addition, in an affidavit submitted by Jessie Westlund, Executive Director of VNA during 1995 and 1996, Ms. Westlund affirmed that the subject newspaper ads had been run in the four newspapers and that "there were no responses to these advertisements." (Provider Exhibit P-11).

The Provider even petitioned the Immigration and Naturalization Service (INS) for a permit to bring a foreign therapist into the country. Although the petition was not granted for the fiscal year at issue, I agree with Ms. Westlund that although VNA's efforts were not successful, that "does not mean that the efforts are invalid or irrelevant to this appeal." Clearly, the Provider was pursuing every available avenue to secure the services of physical therapists.

Given its difficulty in recruiting therapists as employees, the Provider had no choice but to use staffing agencies to ensure that its patients received necessary physical therapy services. The hourly fee charged by three of the staffing agencies ranged from $45.00 to $72.25 (Provider Exhibit P-5). Provider Exhibit P-4 contains representative work orders that substantiate a $55.00 hourly rate. Also, in her affidavit, Ms. Westlund affirms that these charges are accurate, and that VNA had "tried unsuccessfully to negotiate lower rates with some providers, particularly Tipton Hospital and Q Resource, Inc." (Provider Exhibit P-11).

Clearly, VNA was servicing a large rural area that made staffing of therapists very difficult. Its therapy costs, as well as those of other providers in the area, were higher than the guideline limit, and such services were unavailable at the guideline amounts. The Provider submitted adequate documentation substantiating the wage rates it paid its therapists, evidence that it had advertised without any success for therapists on several occasions in newspapers having widespread circulation in the area, and documentation of what it had paid to different staffing agencies for contracted physical therapy services.

The Board majority acknowledges that the Intermediary failed to determine the rates other providers in its area paid for physical therapy services, as required pursuant to HCFA Pub. 15-1 §1414.2. The majority contends that had the Provider submitted substantiating evidence of its need for an exception, the Intermediary's analysis of rates paid by other providers would have assisted in approving or denying the request; but absent such evidence, the Intermediary's analysis would have served little purpose. I disagree.

This information was readily accessible to the Intermediary from the cost report records of other providers in VNA's service area; and had it been submitted to the Board as part of the record of this case, it very likely would have confirmed the Provider's contention that its cost for providing physical therapy services was in line with what other providers in its service area had been paying. If that were the case, the Provider would very likely have prevailed. Unfortunately, the Intermediary's disregard of its obligation pursuant to HCFA Pub. 15-1 §1414.2 resulted in the Provider and the Board being denied the benefit of this relevant and very important information.

Lastly, the Provider's HHA visit costs were capped, and specific limits were applied to physical therapy charges. There was no incentive for the Provider to have paid any more than absolutely necessary for therapy services.

The Provider's exception to the contract physical therapy cost limitations for unique circumstances or special labor market conditions should have been granted.

Gary B. Blodgett

Dissenting Opinion of Suzanne Cochran:

I agree with Board Member Blodgett's dissent but I also write separately to address what I believe to be an unreasonable standard of evidence established by the majority. That standard requires a Provider to submit virtually every shred of paper arguably connected with the issue, even on matters that are not seriously in dispute.

The focus of this type of case is whether the provider paid more than it had to. It hinges then on what local market conditions existed (for example rural, shortage of PTs) and what efforts the Provider made to keep its costs down.

The Provider's request for an exception, both original and supplemented for the hearing, could unquestionably have included more documentation. But, the original request *addressed*, at least in narrative form, all the criteria cited by the regulation and manual. It represented that:

- Provider served a rural area where there were no therapists located;
- Provider had been unable to recruit or hire;
- Provider had tried to be creative in contracting with several services;
- It had placed ads in local papers;
- It had attempted to share therapists with other health care providers;
- It contacted immigration to get a foreign therapist but was unsuccessful until 1996, the following cost report year;
- The efforts had otherwise been fruitless;
- Therapy contracts that it had been able to negotiate had all been above the limit.

I do not disagree with the Intermediary's conclusion that the Provider's narrative along with subsequently furnished contracts and requests to publications to place ads do not prove incontestably that the amounts were actually paid or that the ads were actually placed. Under the circumstances of this case, though, I believe the Intermediary's documentation requirements, endorsed by the majority, go too far. They cease to protect the Medicare trust fund and instead unnecessarily burden it. Moreover, there is no guidance to providers on how much is enough.

The Provider attached some of its contracts to show rates it actually paid. What it did not provide was all the support documents to back up all the statements its narrative. But proof of what it actually paid its PTs only became a contested issue when the Intermediary suggested, without explanation, that the contracts the Provider submitted were not representative of what it actually paid. This is a position that I do not believe the provider could reasonably have anticipated. Amounts actually paid could easily have been verified if this had been a genuine issue. I do not question that the Intermediary is justified in asking for any documentation that it believes it needs. Had the Provider refused or been unable to produce back up documents, the Intermediary would have been justified in denying the claims. However, that did not

happen here. The Provider's claim was rejected because the Provider failed to anticipate what the Intermediary might question.

The Conditions of Participation set out in the regulations require HHAs to provide a therapy service. It is undisputed that HHA visit costs are capped, plus specific cost limits apply to physical therapy services. An HHA, therefore, has little incentive to pay a therapist more than it absolutely has to. Even if the Provider had furnished payment information, how much would have been enough? Would invoices and cancelled checks covering every single service be necessary? Would copies of PT licenses have been required to assure that the individuals paid were indeed licensed therapists? The Intermediary's position here requires a provider to assume that every statement it makes will be disputed, and therefore every piece of documentation that touches on the issue must be furnished.

Likewise, the best evidence of what newspaper ads were placed would have been every newspaper every day the ads were placed. Invoices and checks for the ads would then have been superfluous. Even with all that, it would not have ended the inquiry because the crux of the issue is whether the provider could have negotiated a lower rate. The provider would still have been in a position of proving a negative: that it had no response to the ads. The best, and likely the only evidence, will be what the provider originally submitted: its own statements that it had no response.

The majority's suggestion that the Provider could have submitted a "rejection letter" ignores how business is customarily conducted. Ad readers looking for work aren't likely to write a letter informing the advertiser that their prices are too low; they simply look for a better deal. Perhaps the Provider could have prepared a proposed contract that it knew through verbal negotiations would be rejected to try to "paper" its efforts. But it is certainly doubtful that a prospective therapist would have responded with a writing other than a contract with different terms. The Provider would again be left with nothing but its own statements that therapists would not accept the contract it proffered.

The Provider's evidence directly addressed its efforts. For example, its application to the INS provided its contemporaneous statements that a serious shortage of PTs exists and that it would pay $40-60 per hour. The Intermediary implies that this was not a genuine effort because the petition was denied as being incomplete. I find the Intermediary's position to be nothing short of misleading, however, in that the evidence shows that INS rejected the petition because the provider did not furnish patient identification, including patient addresses, which the provider had explained to INS that it was not permitted by law to furnish. It is inconceivable that the Provider would have gone to such lengths unnecessarily.

I also find the Intermediary's position that it was confused about the Provider's use of the term "waiver" in its request instead of "exception" to be silly. The Provider's meaning was crystal clear. To require magic words creates a technical trap that

frustrates the intent of the exception process. Providers should not have to employ a team of experts to wordsmith their communications with a government contractor.

The Provider's evidentiary submission appropriately addressed the provider's efforts. If the Intermediary had any serious doubts about whether the documents accurately represented what the Provider claimed, it could have easily required verification. The Intermediary's position that the Provider did not submit enough to even trigger its responsibility to make a comparison with other providers' costs in the area is, I believe, a poor excuse for failing to carry out its own responsibilities. Nothing in the Manual suggests that there is such a threshold. Such comparative evidence, uniquely available to the Intermediary, would have been the strongest evidence of the actual labor market for physical therapists. Its conspicuous absence, particularly when it is required, suggests that it would have been unfavorable to the Intermediary.

Suzanne Cochran