PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D61

PROVIDER -
Erwine's Home Health Care, Inc.
Kingston, Pennsylvania

Provider No.: 39-7573

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit Administrators

DATE OF HEARING
June 3, 2005

Cost Reporting Periods Ended -
December 31, 1996 and December 31, 1997

CASE NOS.: 99-1543 and 00-1001

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ISSUE:

Whether the Intermediary's adjustments applying the physical therapy salary guidelines to fee-for-service employee compensation was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Erwine's Home Health Care, Inc. (Provider) is a Medicare-certified home health agency located in Kingston, Pennsylvania. During fiscal years ended December 31, 1996 and 1997, the Provider rendered home health services, including physical therapy services, to its patients. The therapists performing physical therapy were employees of the Provider and were paid on a per-visit basis. They were also entitled to employee benefits from the Provider, including participation in the Provider's pension and health benefits plans. The Provider also paid for worker's compensation insurance for these employees, withheld the employee share of FICA and Medicare taxes for them and paid the employer's share of these taxes.

Wellmark, Inc, the Provider's intermediary for the periods at issue,[1] reviewed the cost reports for fiscal year ends (FYE) 1996 and 1997 and proposed adjustments subjecting

[1] Wellmark, Inc. subsequently was replaced by Cahaba Government Benefits Administrators (the Intermediary).

the compensation paid to the employee physical therapists to the physical therapy compensation guidelines applicable to services furnished under arrangement. The adjustments applying HCFA Pub 15-1 §1403 resulted in a reduction in reimbursement for physical therapy cost in the amount of $10,700 for FYE 1996 and $7,198 for FYE 1997.

The Provider appealed these adjustments to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by Joel Hamme of Powers, Pyles, Sutter and Verville, P.C. and the Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSIONS:

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

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

> [in] situations where compensation, at least in part, is based on a fee-for-service basis or on a percentage of income (or commission), these arrangements will be considered non-salary arrangements, and the entire compensation will be subject to the guidelines in this chapter.

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

> . . . the Act clearly states that physical therapy services performed "under an arrangement" do not include services performed by a physical therapist in an employment relationship with the provider. 42 U.S.C. §1395x(5)(A) reads:
>
> > Where physical therapy services ... are furnished under an arrangement with a provider of services or other organization . . . the amount included in any payment to such provider or other organization . . . as the reasonable costs of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would

> reasonably have been paid for such services . . . to the person performing them *if they had been performed in an employment relationship* with such provider or other organization (*rather than under such arrangement*). . . . (Emphasis added).

> The language of the Act distinguishes between services that are performed by employees of the provider and services that are performed "under an arrangement," and it indicates that services performed by a physical therapist in an employment relationship with the provider are different from those services performed "under an arrangement." The Guidelines, therefore, do not apply to employee physical therapists who are paid on a fee-per-visit basis.

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

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

DECISION AND ORDER:

The Intermediary improperly applied the reasonable compensation equivalency guidelines to the Provider's employed physical therapists who were paid on a fee-for-service basis. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIAPTING:

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

DATE: August 31, 2005

FOR THE BOARD:

Suzanne Cochran
Chairperson