PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D41

PROVIDER -
Comprehensive Home Care, Inc.
Chicago, Illinois

Provider No.: 14-7589

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
August 24, 2005

Cost Reporting Period Ended -
May 31, 1998

CASE NO.: 00-3942

INDEX

ISSUE:

Whether the Intermediary's disallowance of accrued compensation for the Provider's President/Chief Executive Officer (CEO) and Vice President/Operations Manager 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.

The regulation at 42 C.F.R. Section 413.102 (a) states:

> A reasonable allowance of compensation for services of owners is an allowable cost provided that the services are actually performed in a necessary function.

In addition, regulations at 42 C.F.R. Section 413.100 refer to the special treatment of certain accrued costs:

> (a) Principle
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> . . . under the accrual basis of accounting . . . expenses are reported in the period in which they are incurred. In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the year in which the costs are

accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section.

(b) Recognition of accrued costs.

(1) General. Although Medicare recognizes, in the year of accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) Requirements for liquidation of liabilities. For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set for the below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual . . . .

(iv) Compensation of Owners.

Accrued liability related to compensation of owners other than sole proprietors and partners must be liquidated with 75-days after the close of the cost reporting period in which the liability occurs.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Comprehensive Home Care, Inc., (Provider) is a proprietary home health agency located in Chicago, Illinois. The Provider is a privately held corporation that has been a participant in the Medicare Program since November 10, 1994. During the cost reporting period ended May 31, 1998 the Provider rendered home health services to home-bound patients throughout Cook County and other counties in Greater Chicago, Illinois. It rendered approximately 13,349 home visits in 1998, of which 12,643 were to Medicare beneficiaries. The Provider's Medicare utilization was approximately 94.71%.

The Provider submitted its annual Medicare cost reports to its Intermediary of record, Blue Cross and Blue Shield of Illinois (BCBSI), d/b/a Health Care Service Corporation in accordance with Medicare regulations. However, effective September 30, 1998, BCBSI was terminated as a Medicare contractor for Illinois and Michigan after pleading guilty in a *qui tam* lawsuit brought by the U.S. Department of Justice in July 1998.[1] The transition to a new fiscal intermediary, Palmetto Government Benefits Administrators (Palmetto GBA or Intermediary) occurred sometime thereafter.

[1] U.S. ex rel. Knoob v. Health Care Service Corporation (SD IL No. 95-4071-JLF).

The Provider claimed compensation for the services provided by its two owners, who held the positions of President/CEO and Vice-President/ Operations Manager in the amount of $90,270 and $85,270, respectively. The owners' salaries for the period in question were not paid in full. Of the $175,540 of compensation claimed, $128,540 was accrued and payment was deferred by the issuance of promissory notes on May 1, 1998, in the amount of $64,270 to each owner.

Both promissory notes were due and payable on May 1, 2003. However, the principal amount of the notes could be prepaid, in whole, [or in part], at any time prior to maturity.[2] The Provider did not liquidate any portion of the liability within 75 days after the close of its FYE 5/31/98 cost reporting period.[3]

The Intermediary disallowed the costs of owners' compensation related to these promissory notes. The Provider was dissatisfied with the Intermediary's adjustment and requested a hearing before the Board. The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R. §§405.1835-405.1841. The amount of Medicare reimbursement in dispute is approximately $122,000.

The Provider was represented by Charles F. MacKelvie, Esquire, of The MacKelvie Law Firm. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, the parties' contentions and the evidence presented, finds and concludes as follows:

Medicare regulations and program instructions allow reimbursement for reasonable compensation a provider pays its owners, but with certain restrictions. Through a revision to CMS Pub. 15-1 §906.4 contained in Transmittal No. 391,[4] CMS clarified its policy regarding the liquidation of owner's compensation. The Transmittal states, in relevant part, that the policy has been revised to specify that:

> . . . where a provider's payment to a corporate owner for compensation is made by check or other negotiable instrument, the negotiable instrument must be liquidated through an actual transfer of the provider's assets within 75-days after the close of the cost reporting period in order for the compensation to be included in allowable cost for that period.

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[2] Intermediary's Position Paper dated 9/20/2004. Exhibit I-2 – Promissory Notes dated 5/1/1998 for Lucy Mohen, President/CEO and Mary Freedman, VP/Operations Manager. Also See Stipulations of Facts No. 3.

[3] See Stipulations of Facts No. 5.

[4] See Exhibit I-3.

The Board finds that the Secretary of the DHHS is given broad authority to issue regulations to implement Medicare laws. In addition, CMS may establish interpretative rules, general statements of policy, or rules of agency organization, procedure or practice. The issuance of program instructions in the PRM is an example of interpretative rules that may be established. Accordingly, the Board finds reasonable the Secretary's establishment of a 75-day rule for the timely liquidation of negotiable instruments issued in payment of owner's compensation.

The parties agree that the Provider did not liquidate its owners' compensation liability within 75 days after the close of the Provider's fiscal year (i.e., on or before July 14, 1998). In fact, the Intermediary was not notified until September 2000 that the liability had been paid in full as of March 1999. The Provider's argument that the program instructions in Transmittal No. 391 and CMS Pub. 15-1 §906.4 are not entitled to be given the force of law is correct; however, the Board does afford great weight to these interpretative rules. The Board concludes that the program instructions in Section 906.4 of the PRM are reasonable and applicable to this provider since the negotiable instrument (promissory note) was not liquidated within 75-days of the end of the fiscal year.

The Provider argues that CMS Pub. 15-1 §2305.1 provides for a "good cause" extension of time for the liquidation of liabilities. The Boards finds, however, that §2305.1 specifically exempts costs subject to a 75-day liquidation rule from the application of the extension provision. Rather, liquidation of liabilities for owners' compensation is governed by CMS Pub. 15-1 §906.4. Moreover, while there were extenuating circumstances beyond the Provider's control, which may have justified an extension of time to liquidate the liability assuming such a provision applied, there was no evidence presented that the Provider made a written request for an extension for "good cause" in accordance with the instructions.

The Provider also argues that the Intermediary should be estopped from applying the 75-day limitation in CMS Pub. 15-1 §906.4 because Intermediary delays in payment caused the Provider's inability to liquidate its owners' compensation liability. The Provider asserts that these circumstances are particularly egregious because the delays were caused when the Intermediary had to be changed after the first Intermediary was determined to have committed fraud in its dealings with Medicare. The Board finds that it has no authority to promulgate an equitable remedy.

Finally, the Provider argues that: (1) Generally Accepted Accounting Principles (GAAP) permit owners' compensation supported by a negotiable instrument to be included on the Provider's financial statement for FYE 5/31/98, and (2) Illinois state law supports the Provider's position that notes are liquidated at the time of delivery or receipt. The Board finds these arguments irrelevant and inapplicable when specific Medicare regulations and program instructions exist.

DECISION AND ORDER:

The unpaid owners' compensation claimed by the Provider is not allowable. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: July 28, 2006

Suzanne Cochran
Chairperson