PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D25

PROVIDER -
MGH Home Health
Olney, Maryland

Provider No.: 21-7118

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Government Benefit
Administrators

DATE OF HEARING -
December 6, 2005

Cost Reporting Periods Ended -
June 30, 1996 and June 30, 1997

CASE NOs.: 01-1397 and 01-1398

INDEX

ISSUE:

1. Whether the Intermediary's application of Medicare's physical therapy guidelines to physical therapists paid on a per-visit basis was proper. (Applies to both cost reporting periods at issue - - case numbers 01-1397 and 01-1398.)

2. Whether the Intermediary's adjustment to include charity care home health visits in the calculation of the Provider's program reimbursement was proper. (Applies only to the Provider's fiscal year 1996 cost reporting period--case number 01-1397.)

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative 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 portion 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 NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

MGH Home Health (Provider) is a free-standing home health agency located in Olney, Maryland. During its Medicare cost reporting periods ended June 30, 1996 and June 30, 1997, the Provider employed physical therapists who were paid based upon the number of home care visits they performed, i.e., they were paid on a "per-visit" basis. Cahaba Government Benefit Administrators (Intermediary) reviewed the Provider's cost reports for each of these periods and applied Medicare's reasonable compensation guidelines (limits) to the cost of these physical therapists, which reduced the Provider's program reimbursement.

With respect to this matter, 42 U.S.C §1395x(v)(1)(A) of the Social Security Act (Act) provides that the reasonable cost of any service shall be the actual cost incurred excluding

any part of such costs found to be unnecessary in the efficient delivery of needed health services. The statute also authorizes the Secretary of DHHS to establish cost limits. Essentially, the limits recognize reasonable costs based upon estimates of costs found to be necessary in the efficient delivery of covered items and services.

Regarding therapy costs, 42 U.S.C §1395x(v)(5)(A) states:

> [w]here physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) 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 under this subchapter as the reasonable cost 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) plus the cost of such other expenses . . . incurred by such person, as the Secretary may in regulations determine to be appropriate.

The implementing regulation at 42 C.F.R. §413.106 states:

> (a) *Principle*. The reasonable cost of the services of physical, occupational, speech, and other therapists, and services of other health specialists (other than physicians), furnished under arrangements (as defined in section 1861(w) of the Act) with a provider of services, a clinic, a rehabilitation agency or a public health agency, may not exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider or other organization had such services been performed by such person in an employment relationship, plus the cost of other reasonable expenses incurred by such person in furnishing services under such arrangement. However, if the services of a therapist are required on a limited part-time basis, or to perform intermittent services, payment may be made on the basis of a reasonable rate per unit of service, even though this rate may be greater per unit of time than salary-related amounts, if the greater payment is, in the aggregate, less than the amount that would have been paid had the therapist been employed on a full-time or regular part-time salaried basis.

With regard to the second issue, during the cost reporting period ended June 30, 1996, the Provider furnished 115 charity care home health visits that it excluded from the calculation of its Medicare reimbursable costs, i.e., it excluded these visits from “total

visits" shown on Worksheet S-3 of its Medicare cost report. The Intermediary, however, made an adjustment to include the charity care visits in the Provider's total visit count, which served to reduce the Provider's program reimbursement. During this period the Provider was essentially reimbursed based upon a "cost per visit" determined through the Medicare cost report process. The Provider's direct and indirect costs were statistically grouped to determine a total cost for each discipline of service the Provider furnished, e.g., skilled nursing care, physical therapy, and speech therapy. Each discipline's total cost was then divided by the total number of visits made for that service (i.e., the total of both Medicare and other or non-Medicare patient visits) to determine a cost per visit per discipline. The Provider's costs per visit were then multiplied by the number of Medicare visits made in each discipline to apportion costs to the Medicare program (determine program reimbursement). Accordingly, an increase to the Provider's total visits decreased its cost per visit and, correspondingly, its Medicare reimbursement.

The Provider appealed the Intermediary's adjustments to the 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 approximately $34,900 ($25,900 resulting from the Intermediary's adjustment to the Provider's physical therapy costs in 1996 and 1997, and $9,000 resulting from the Intermediary's adjustment to charity care visits in 1996).[1]

The Provider was represented by Carel T. Hedlund, Esq., of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue No. 1. Application of Medicare's Reasonable Compensation Guidelines to Employee Physical Therapists

The Provider contends that the controlling statute and regulations apply the guidelines to the cost of therapy services performed "under arrangement," which are services performed by "outside contractors," not bona fide employees as in the instant case.[2] To the extent that Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §1403 treats employees paid on a fee-for-service basis as nonsalaried arrangements, it is inconsistent with the statute and regulations and is therefore invalid. Also, it is clear that HCFA Pub. 15-1 §1403 is intended to prevent employment relationships from being used to circumvent the guidelines. However, paying therapists on a per-visit basis was prompted by an Internal Revenue Service (IRS) effort to identify employees misclassified as independent contractors. The Provider refers to Private Letter Ruling 9208012 in which the IRS determined certain health care professionals, including therapists, to be employees of a home health agency rather than independent contractors.[3] The Provider

[1] Provider's Position Papers at 2.

[2] Provider's Position Papers at 9. Exhibit P-5.

also cites In Home Health, Inc. v. Shalala , Civ. No. 97-2598 [1998-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 300,005 (D. Minn. June 6, 1998), affm'd, In Home Health, Inc. v. Shalala , No. 98-3141 [1999-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 300,326 (8th. Cir. Sept. 1, 1999) and, High Country Home Health v. Shalala , Case No. 97-CV-1036-J, [2000-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 300,411 (D. Wyo. Dec. 20, 1999), upholding the Board's decisions that neither the statute nor regulations provide a basis for applying the guidelines to employed physical therapists.

The Provider contends that had the Intermediary compared the cost of its physical therapists with the costs incurred by other similarly situated providers, the Intermediary would have determined that none of the Provider's physical therapy costs were "substantially out of line" in accordance with Medicare's prudent buyer principle. 42 C.F.R. §413.9(c)(2).

And finally, the Provider states that 42 C.F.R. §413.106(c) was amended effective April 1, 1998, to include physical therapists paid based upon a fee-for-service within the scope of the regulation. However, the Provider also explains that this revision was made after the subject cost reporting periods and can not be applied retroactively to support the Intermediary's adjustments.

The Intermediary contends that its application of HCFA Pub. 15-1 §1403 to the Provider's employee physical therapists is, in effect, an application of Medicare's prudent buyer principle. This position is supported by both CMS and the Blue Cross Blue Shield Association (Exhibits I-5 and I-6) and 42 C.F.R. §413.106(c)(5), which states "[u]ntil a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost conscious buyer would pay for the given service."[4]

The Intermediary contends that therapists paid on a per-visit basis are subject to the guidelines pursuant to HCFA Pub. 15-1 §1403, which states " [i]n situations where compensation, at least in part, is based on a fee-for-service or on a percentage of income (or commission), these arrangements will be considered nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter." The Intermediary notes that this provision recognizes that certain salaried employment relationships could be used to circumvent the guidelines.

Also, the Intermediary contends that the April 1, 1998 amendment to 42 C.F.R. §413.106(c), which brought physical therapists paid on a fee-for-service basis within the scope of the guidelines, was not a substantive change in Medicare policy. Rather, the Intermediary asserts that the regulation was changed based upon the long-standing policy contained in HCFA Pub. 15-1 §1403.

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[3] Id. Exhibit P-18.
[4] Intermediary Position Papers at 4.

Issue No. 2. Charity Care Home Visits

The Provider contends that section 218.1 of the Medicare Home Health Agency Manual defines a home health visit as an "episode of personal contact with the patient by staff of the HHA . . . for the purpose of providing a covered home health service." Moreover, the Provider asserts that section 218.3 of the manual adds that the encounter must be "billable" to be a visit. Accordingly, the Provider concludes that charity visits are not "visits" for Medicare purposes since they are not billable, and are, therefore, properly excluded from the total visit count.[5]

The Intermediary contends that the decision of whether or not a visit should be included in the Medicare cost report cost-finding process is not based on a patient's ability to pay but is based on whether or not the visit is the same type that would be covered by Medicare, i.e., a "like-kind visit".[6] If a visit is not of like-kind, the cost of the service should be reported in a non-reimbursable cost center. With respect to the instant case, the cost of the non-reimbursable charity care visits has been included in the Provider's cost report. Therefore, the appropriate method of excluding these costs from Medicare reimbursement is to include the charity care visits in total visits and allow the cost per visit to calculate appropriately.

The Intermediary cites Medicare's cost report instructions at HCFA Pub. 15-1 §3205, which state in part:

> [i]n preparing the cost report, recognize only the costs associated with Medicare-type like-kind visits in reimbursable cost centers. Medicare like-kind visits generally fall under the definition of Medicare visits . . . In counting like-kind visits, it is critical that non-Medicare visits are of the same type as those that would be covered by Medicare. This insures that costs of services are comparable across insurers and the providers are reimbursed equitably for home health services provided.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue No. 1. Physical Therapist Costs

The Provider employed physical therapists which it paid a lump sum for each patient visit performed. The Intermediary applied the salary equivalency guidelines contained in HCFA Pub. 15-1 §1400 to the therapists' compensation, thereby reducing the Provider's allowable program costs and reimbursement.

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[5] Provider Position Paper, Case No. 01-1397, at 19 and 20.

[6] Intermediary Position Paper, Case No. 01-1397, at 9.

The Intermediary contends that applying the guidelines to the Provider's costs is appropriate pursuant to HCFA Pub. 15-1 §1403, which states:

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

In addition, the Intermediary contends that application of the guidelines to employee physical therapist costs is appropriate pursuant to Medicare's prudent buyer principles. The Intermediary asserts that the fact the Provider's costs exceed the guidelines indicates that they are substantially out of line with the costs incurred by other providers and are, therefore, unreasonable.

The Board finds, however, that the Intermediary's application of the guidelines to the Provider's costs is improper. 42 U.S.C. § 1395x(v)(5)(A), the controlling statute, distinguishes services performed by employee therapists from services performed by outside contractors "under an arrangement" with a provider. Both the legislative history and regulatory history of the guidelines indicate that they were created to prevent perceived abuse in the practices of outside physical therapy contractors as opposed to provider employees. Moreover, the Board notes that the term "under an arrangement" is commonly referred to and used interchangeably with the term "outside contractor." Accordingly, the Board finds the guidelines do not apply to employee physical therapists even though they are paid on a fee-for-service basis.

As noted in previous cases, the Board cites to In Home Health, Inc. v. Shalala, 188 F.3d 1043 (8th Cir. 1999) and High Country Home Health, Inc. v. Shalala, 84 F. Supp. 2d 1241 (D. Wy. 1999), finding, in part:

> 42 U.S.C. §1395x(v)(5)(A) does not provide a basis for the application of the Guidelines to In Homes' employee physical therapists. The first part of the sentence in 42 U.S.C. §1395x(v)(5)(A) explains that the subsection applies to persons providing physical therapy services "under an arrangement" with a provider. The second part of the sentence explains that the reasonable cost of compensation for the persons "under an arrangement" is calculated by reference to the salary which would have reasonably been paid to the person if that person had been in an "employment relationship" with the provider. The plain meaning of 42 U.S.C. §1395x(v)(5)(A) and 42 C.F.R. §413.106, which uses similar language, distinguishes between services provided "under an arrangement" and those provided by a person in an "employment relationship." It is clear from the language that a physical therapist who is "under an arrangement" is different from a person in an "employment relationship" with the provider. The Guidelines apply to a person "under an arrangement." The final notice in the Federal Register indicates that a person "under an arrangement" is an outside contractor. The Secretary's

> attempt to now further limit the term "employment relationship" to mean only salaried employees is not supported by the statute or the Secretary's contemporaneous interpretation as reflected in the 1992 regulation . . . . Thus, the statute requires nothing more than that a provider should be reimbursed for the services performed by a nonemployee, i.e., an outside contractor working under an arrangement with the provider, similarly to what an employer reasonably would pay its employee for such services. Services provided by a provider's employee are themselves subject to a reasonableness requirement. See 42 U.S.C. §1395x(v)(1). . . . We affirm the district court's reversal of the Secretary's decision and hold that the secretary may not apply the Guidelines to In Home's employee physical therapists.

The Board also finds that the guidelines alone can not be used to adjust a provider's costs in accordance with Medicare's prudent buyer principle. Rather, 42 C.F.R. §413.9 indicates that intermediaries must determine whether or not a provider's costs are "substantially out of line" or are unreasonable based upon a comparison of those costs to those incurred by other similarly situated providers.

And finally, the Board finds that the amendment made to 42 C.F.R. §413.106(c)(5), which applies the guidelines to therapist costs where compensation was based, at least in part on a fee-for-service, does not apply to the instant case. The amendment was published on January 30, 1998, and effective for services furnished on or after April 1, 1998, which is after the subject cost reporting periods.[7]

Issue No. 2. Charity Care Home Visits

The Provider furnished 115 charity care visits which it excluded form its Medicare cost report and the calculation of its cost per visit (per discipline of service) used to determine Medicare reimbursement. The Provider concluded that the charity visits should be excluded because no "billable service" was performed. In reaching this conclusion, the Provider relied upon section 218.3 of Medicare's Home Health Agency Manual, which discusses "evaluation visits." Essentially, the Provider equated the manual's instruction excluding evaluation visits from the cost report (i.e., visits in which no individual or third party payer would be billed) to mean that non-billable visits in general should be excluded.

The Board, however, disagrees. 42 C.F.R. §409.48(c), which defines an HHA visit, does not require an episode of personal contact with a patient to be billed/billable in order to be deemed a visit. Rather, the regulation only requires that the reason for the episode be for the purpose of providing a covered service. Notably, the Provider does not dispute that the subject visits were performed to furnish a covered service, but only that they did not bill for them.

[7] Exhibit P-15.

Having concluded that the program recognizes visits even though no billing was made for the services, 42 C.F.R. §413.53(a)(3) requires that they be included in the Provider's total visit statistics within the Medicare cost report. In pertinent part, the regulation states:

> *Cost per visit by type-of-service method—HHAs*. For cost reporting periods beginning on or after October 1, 1980, all HHAs must use the cost per visit by type-of-service method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. (Emphasis added).

Application of these rules in the instant case is essentially the same as the Board's findings in Maxicare, Inc. v. Blue Cross Blue Shield Association/Palmetto Government Benefit Administrators, PRRB Dec. No. 2000-D55, May 30, 2000, decl'd rev., CMS Admin., July 18, 2000 (Maxicare). In Maxicare, program payments for home health visits were denied because the visits were performed outside of a physician's plan of treatment. Nonetheless, the Board found that "visits" were performed according to the definition at 42 C.F.R. §409.48(c), and that they must be included in the provider's total visit statistics according to 42 C.F.R. §413.53(a)(3) quoted above.

In conclusion, the Board finds that excluding the charity care visits from the Provider's total visit statistics would improperly shift the non-reimbursable costs of the charity care visits to the Medicare program.

DECISION AND ORDER:

Issue No. 1. Physical Therapist Costs

The Intermediary's application of Medicare's salary equivalency guidelines to the compensation of physical therapists employed by the Provider but paid on a per-visit basis was improper. The Intermediary's adjustments are reversed.

Issue No. 2. Charity Care Home Visits

The Intermediary's adjustment which included the Provider's charity care home health visits in the calculation of the Provider's program reimbursement was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Elaine Crews Powell, C.P.A

FOR THE BOARD:

DATE: June 1, 2006

Suzanne Cochran, Esq.
Chairman