PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D39

PROVIDER -
VNA of Maryland, LLC
Baltimore, Maryland

Provider No. 21-7008

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Cahaba Government Benefits
Administrator

DATE OF HEARING-
May 2, 2001

Cost Reporting Period Ended -
June 30, 1996

CASE NO. 00-2472

INDEX

ISSUE:

Was the Intermediary's adjustment subjecting the compensation of employed physical therapists paid on a per visit basis to the contract physical therapy guidelines proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

VNA of Maryland (Provider) is a component of a chain organization located in Baltimore, Maryland. The Provider employed physical therapists and compensated them on a per visit basis. These employees received all of the ordinary fringe benefits that other employees of the Provider received. The Provider paid FICA and other payroll taxes for these employees. The Provider did not file the cost related to these employees on Worksheet A-8-3 of the Medicare cost report.

The Intermediary adjusted the cost of the physical therapists in accordance with the Contract Therapy guidelines contained in HCFA Pub. 15-1 §1400 et seq. As a result of this adjustment, the Provider exceeded the Contract Therapy Guidelines ("Guidelines") by $1.66 per visit. This resulted in a disallowance of $23,169. The Provider disagreed with this adjustment and timely appealed to the Provider Reimbursement Review Board ("Board"). The Board determined that the Provider met the relevant requirements of 42 C.F.R. §§405.1835-1841. The amount of Medicare reimbursement in controversy is approximately $21,000.

The Provider was represented by George J. Pinel, CPA of Davis, Pinel & Associates, Inc.
The Intermediary was represented by Eileen Bradley, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Physical Therapy Guidelines contained in HCFA Pub. 15-1 § 1400 et seq. should not be applied to employed physical therapists. There is no regulatory authority supporting the application of the Guidelines to Provider employees. The Social Security Act specifically provides for limits on Medicare payments for certain physical therapy services furnished by providers. The Provider points out that where physical therapy services are furnished under an arrangement with a provider of services or other organization, the amount included in any payment to a provider or other organization as the reasonable costs of such services should 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 costs of such other expenses incurred by such person as the Secretary may in the regulations determine to be appropriate.

The Provider points out that the Secretary promulgated regulations that apply to physical therapy services, entitled "Reasonable Cost of Physical and Other Therapy Services Furnished Under Arrangements," at 42 C.F.R. §413.106. That regulation states in part:

> The reasonable cost of the services of physical.. .therapists. . . furnished under arrangements.. .with a provider of services.. .may not

> exceed an amount equivalent to the prevailing salary and additional costs that would reasonably have been incurred by the provider.. .had such services been performed by such person in an employment relationship.

The Provider argues that the Law and Regulations cited clearly direct that the Guidelines are intended to prevent services obtained under arrangements from exceeding what a provider would have incurred had the services been provided under an employment relationship. There is no reference in the Medicare regulations directing intermediaries to apply the Guidelines to employed therapists. Since 1975 the actual cost limits have been issued periodically in the Federal Register as the Salary Equivalent Guidelines. The Provider contends that the federal register, 48 F.R. 44922 (Sept. 30, 1983) is the governing authority for the Provider's year under contention.

The language from the Federal Register directs that the guidelines do not apply to the services furnished by employees of a hospital or other provider. It states in part:

> The regulations further provide that HCFA will issue guidelines establishing the hourly salary equivalency amounts for therapy services furnished to Medicare beneficiaries under arrangements. These guidelines with updates as necessary, apply only to the amount of reimbursement the Medicare program will make to a provider for therapy services obtained under an arrangement. The guidelines are not intended to dictate or otherwise interfere in the terms of the contract that a provider may wish to enter into with a therapist or therapist organization. The guidelines do not apply to services furnished by employees of a hospital or other provider; the part of these services will continue to be evaluated under the Medicare program's reasonable cost provisions. (See 42 C.F.R § 405.451).

48 F.R. 44922 (Sept. 30, 1983).

The Provider points out that in January 1998 HCFA issued updated therapy guidelines in Federal Register, 63 F.R. 5106 (Jan. 30, 1998), which stated:

> However, we are establishing regulations that provide that the salary equivalency guidelines will apply to situations where compensation, at least in part, to a therapist employed by the provider is based on a fee-for-service or on a percentage of income (or commission). The entire compensation will be subject to the guidelines in cases where the nature of the arrangements are most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The guidelines will be applied in this situation so that an employment relationship is not being used to circumvent the guidelines.

Id.

The Provider points out that the regulation now contains the following provision:

> If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under "arrangement" situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

42 C.F.R. § 413.106(5) et seq.

The Provider maintains that there is no dispute by the Intermediary that the physical therapists were bona fide employees of the Provider. The physical therapists received fringe benefits and had payroll taxes withheld just as other Provider employees. Therefore, the issue is simply whether the Guidelines should apply to employee physical therapists.

The Provider contends that the original regulation did not provide for the application of the Guidelines to employed therapists. It was only after HCFA's revisions in the 1998 Federal Register that the regulations were applicable to employed therapists. This change is two years after the year under appeal. Both the revised regulations and HCFA Pub. 15 instructions state that "the intent of this section is to prevent an employment relationship from being used to circumvent the guidelines." 42 C.F.R. § 413.106 et seq.

The Provider points out that the cost per visit of the salaried physical therapist was $57.35. The guideline amount including the salary equivalent, the travel allowance and the travel expense component came to $56.20. Therefore, the PT employees of the Provider are only over the guidelines by $1.15. By way of contrast, the average cost per visit for the VNA's contract therapist was $54.49. Therefore, the disparity between the rates of the employed therapist and the contract therapist is insignificant. Moreover, the Provider is only marginally above the contract guidelines. Therefore, the Provider was not utilizing an employment relationship to circumvent the guidelines. The rates that the Provider paid for both employees and contractors were below what other providers in Maryland were paying.

The Provider contends that the U.S. Court of appeals for the Eighth circuit recently held in favor of the provider in In Home Health v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 96-D16R, Feb. 27, 1996, HCFA Admin. Rem'd; Medicare & Medicaid Guide (CCH) ¶45,129, In Home Health Inc, v. Shalala, U.S. Dist. Court, District of Minnesota, Civil No. 3 97-2598/RHR/ FLN, June 16, 1998 Medicare & Medicaid Guide (CCH) ¶300,005. The court stated in part:

> We find that 42 U.S.C. §1395x(v)(5)(A) does not provide a basis for

> the application of the guidelines to In Home's 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 reasonably have 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." . . . 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)(l). . .We affirm the districts 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.

Id.

The Provider points out that the intermediary adjustment was reversed in the All-Care Home Health Services v. Blue Cross and Blue Shield Association and Blue Cross of Iowa d/b/a Wellmark, Inc. PRRB Dec No. 2000-D63, and Capitol Home Health-Marksville v. Blue Cross and Blue Shield Association and Blue Cross of Iowa d/b/a Wellmark, Inc., PRRB Dec. No. 99-D65 In the text of the All-Care decision the Board stated:

> The Intermediary improperly applied the physical therapy guidelines to the wages paid to the Provider's employee physical therapists resulting in an improper adjustment to the Provider's cost report. The Board finds that the issue in this case is the application of the physical therapy guidelines to the wages paid to the Provider's employee physical therapists. Based on the evidence in the record, the Board finds that the physical therapists in dispute are bona fide employees of the Provider....

Id.

The Provider contends that it is clear from the above mentioned cases that the courts and the PRRB have consistently ruled in the Provider's favor in similar situations.

The Provider points out that physical therapist services were in great demand during the mid-nineties. There were many times when the Provider was unable to maintain sufficient staff to meet the needs of its patients. The fact that the rates paid to employee staff only marginally exceeded the guidelines was a tribute to the Provider's management and recruitment efforts. In response to the difficulties of obtaining sufficient staff the Intermediary granted many providers in the Baltimore marketplace an exception to the guidelines in accordance with HCFA Pub. 15-1 § 1412. The Provider did not need an exception at the time the report was filed because it did not exceed the guidelines on its filed cost report.

The Provider points out that the average cost per visit, for contract and employed therapists, for the Baltimore MSA providers for the period October 1, 1992 through September 30, 1993 was $48.73 and $72.96 respectively. For the calendar year 1994 the average contract cost per visit was $63.66 and the salary cost per visit was $58.56. The Provider contends that it had an overall therapy cost of $58.82 which was only $0.66 above the guideline and clearly in line with other providers in the Baltimore area.

The Provider argues that if the adjustment to include employed physical therapists is not eliminated, it is entitled to an exception to the limits in accordance with HCFA Pub. 15-1 §1414.2. That section states in part:

> 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 the unique circumstances or special labor market conditions in the area... .It is the responsibility of the intermediary to determine the rates that other providers in the area generally have to pay therapists or other health specialists.

Id.

The Provider argues that although HCFA Pub. 15-1 § 1414.2 governing exception requests states that it "must be submitted to the Intermediary each year, no later than 90 days after the close of its cost reporting period." The filed cost report contained no violation of the guidelines. It was not until the Intermediary adjustment subjected Employee Therapists to the Guidelines that the Provider exceeded the guidelines. Accordingly, the requirement that the exception be filed with the submitted cost report is meaningless in the case at hand and should be disregarded.

The Provider argues that the Guidelines were issued in the federal register, 48 F.R. 44922 (Sept. 30, 1983) and was based on the Bureau of Labor Statistics (BLS) survey of 1981 hospital wages. Therefore the Guidelines being applied to the Provider were fifteen years old. The Provider maintains that the marketplace for physical therapy has changed during this time. Prior to 1983, the prevalent health care payment system was cost reimbursement. By 1996, all acute care hospitals and many ancillary providers were in a prospective payment system. It is incorrect to ignore this influence upon the compensation ranges of physical therapists. One measure of the increase in therapist compensation that has occurred over this time period are the guidelines that were issued in 63 F.R. 5106 (Jan. 30,

1998). Effective with dates of service after April 10, 1998 the Guidelines for the Baltimore, Md. Area are as follows:

Average hourly salary equivalency	$52.01
Standard travel allowance	$26.01
Standard travel expense	$ 3.10
Total physical therapy guideline	$81.12

The increased Guideline amount allowed by the new regulations from 1996 to 1998 was $24.96. The data sources utilized to establish the Guidelines in 63 F.R. 5106 (Jan. 30, 1998) were based on a blend of surveys from 1991 to 1994. Accordingly, this data is clearly more representative of the market place than the 1981 survey data that was used to make the adjustment.

The Provider contends that another problem with the Guidelines issued in 1983 is that the Federal Register called for a .6% increase for each elapsed month between October 1, 1982 and the beginning of the Provider's cost report in the event that a revised schedule of limits was not issued. The .6% per month increase contained in the Federal Register was not compounded; rather the number of months from October 1, 1982 is simply multiplied by .6% to derive the Guideline amount. Had the Guideline amount been compounded, by FYE June 30, 1996 the amount would have been $69.75 or $13.56 higher than the actual amount utilized in the adjustment. Had the inflationary effect been compounded, the Provider would have been significantly below the Guideline amount.

The Provider contends that the Intermediary should have adjusted the travel expense rate on the cost report. Had they done this, the amount in excess of the Guidelines would have decreased from $23,169 to $13,099 and the Provider would have been entitled to an additional $9,117 in Medicare reimbursement. This is because effective with the services furnished after January 1, 1995 the travel expense rate was increased from $2.50 to $3.00. Effective with services furnished after June 6, 1996 the travel expense rate was increased from $2.50 to $3.10.

INTERMEDIARY' S CONTENTIONS:

The Intermediary contends that its audit adjustment was made in accordance with the provisions of Medicare regulations 42 C.F.R. § 413.9 et seq. Cost related to patient care, 42 C.F.R. § 413.106- Reasonable cost of physical and other therapy services furnished under arrangements, HCFA Pub. 15-1 chapter 14, and section 2103- prudent buyer.

The Intermediary does not dispute that the physical therapists were employees; however, the Intermediary argues that HCFA Pub. 15-1 applies to certain salaried employment relationships. Section 1403 states in part:

> In 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 contends that compensation of the physical therapists in question was based solely on a fee-for-service arrangement. Therefore, the compensation of these therapists must be treated as non-salary arrangements, the same as outside suppliers, and compared to physical therapist Guidelines.

The Intermediary points out that in HCFA Pub. 15-1 §1403, there are several situations in which compensation of a salaried physical therapist would be subject to the chapter limitations. That section states in part:

> the costs of the services of a salaried employee who was formerly an outside supplier of therapy or other services, or any new salaried employment relationships will be closely scrutinized to determine if an employment situation is being used to circumvent the guidelines. Any costs in excess of an amount based on the going rate for salaried employee therapists must be fully justified.

Id.

The Intermediary points out that the HCFA Administrator's reversal of the Board's Decision in High Country Home Health Care v. Blue Cross and Blue Shield Association. et al, PRRB Dec. No. 97-D35, May 20, 1997, substantiates its position. In that decision, the HCFA Administrator ruled that the intermediary properly applied the Salary Equivalency Guidelines to the per visit compensated physical therapists.

The Intermediary also points out that in In Home Health v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 96-D16R, Feb. 27, 1996, HCFA Admin. Rem'd; Medicare & Medicaid Guide (CCH) ¶ 45,129, the HCFA Administrator decided that the form of compensation, i.e., fee-for-service, of the therapists, as opposed to the employment relationship, was the controlling factor in the application of the limits. HCFA Pub. 15-1 §2102.1 states:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service.

Id.

The Administrator noted that if a prudent buyer analysis were to be applied, the Guidelines themselves establish HCFA's determination of costs, which are reasonable in the marketplace. Costs in excess of the Guidelines are, in effect, determined to be unreasonable. The regulation at 42 C.F.R. § 413.106 et seq states: "Until 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." Id. That regulation is implemented by HCFA Pub. 15-1 § 1403 which states: "Until specific guidelines are issued for the evaluation of the reasonable costs of other services furnished by

outside suppliers, such costs will continue to be evaluated under the Medicare programs requirement that only reasonable costs be reimbursed." Id.

The Intermediary contends that the relevancy of the above is that HCFA Pub. 15-1 effectively establishes specific guidelines for application of the prudent buyer principle. This position is supported by HCFA and is offered as support that the audit adjustment in dispute is in accordance with Medicare regulations at 42 C.F.R. § 413.9 et seq. That regulation states:

> The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.

Id.

The Intermediary argues that the fact that the Provider's physical therapy costs exceeded the physical therapy guidelines proves that the costs are not reasonable and that they are, in fact, substantially out of line. HCFA Pub. 15-1 §2103 states that a prudent and cost conscious buyer refuses to pay more than the going price for an item or service and seeks to economize by minimizing cost. The amount paid by the Provider for physical therapy services was substantially out-of-line to the extent of $23,169.

The Intermediary notes that it neglected to adjust the standard travel expense rate. The rate should be adjusted. The Intermediary also notes that the AHSEA rate should be revised from $35.46 to $34.18 and the standard travel allowance should be reduced from $17.73 to $17.09. These corrections will result in an increase in the amount over the allowance of $27,869. The total resulting disallowance will be $51,038.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.

   § 1395 et seq. - Prohibition against any Federal Interference

2. Regulations - 42 C.F.R.:

   §405.451 - Cost Related to Patient Care

   §§405.1835-.1841 - Board Jurisdiction

   § 413.9 et seq. - Cost Related to Patient Care

§ 413.106 et seq	-	Reasonable cost of Physical Therapy Services Furnished Under Arrangements

3. Program Instructions - Provider Reimbursement Manual, Part 1, HCFA Pub. 15-1:

§ 1400 et seq	-	Reasonable Cost of Therapy and Other Services Furnished by Outside Suppliers
§ 1403	-	Guideline Application
§ 1412	-	Additional Allowances
§ 1414.2	-	Exception Because Unique Circumstances or Special Labor Market Conditions
§ 2102.1	-	Reasonable Cost
§ 2103	-	Prudent Buyer

4. Cases:

All-Care Home Health Services (Rancho Cordova, Cal.) v. Blue Cross and Blue Shield Association /Blue Cross and Blue Shield of Iowa d/b/a Wellmark, Inc., PRRB Dec. No. 2000-D63, June 8, 2000, Medicare and Medicaid Guide ("CCH") ¶ 80,509.
Capital Home Health-Marksville, Marksville, La v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 99-D65 August 27, 1999, Medicare and Medicare Guide ("CCH") ¶ 80,330.

High Country Home Health Care v. Blue Cross and Blue Shield Association et al, PRRB Dec. No. 97-D35, May 20, 1997, Medicare and Medicaid Guide ("CCH") § HCFA Adm. Dec. Medicare and Medicaid Guide (CCH) ¶45,543.

In Home Health v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No. 96-D16R, Feb. 27, 1996, HCFA Admin. Rem'd; Medicare & Medicaid Guide (CCH) ¶ 45,129, In Home Health Inc, v. Shalala, U.S. Dist. Court, District of Minnesota, Civil No. 3 97-2598/RHR/ FLN, June 16, 1998 Medicare & Medicaid Guide (CCH) ¶300,005.

5. Other:

48 F.R. 44922 (Sept. 30, 1983).
63 F.R. 5106 (Jan. 30, 1998).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, the facts, and parties contentions, finds and concludes that there are two subissues that it must decide. The first is whether the physical therapy guidelines apply to fee-for-service employees. The second is the prudent buyer concept.

The Board finds that the Provider and the Intermediary agree that the physical therapists are bona-fide employees of the Provider. Therefore, in regard to the first argument, the Board finds that the language of the Act at 42 U.S.C. § 1395x(v)(5)(A) distinguishes between services that are performed by employees of a 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 the services performed " under an arrangement." The guidelines, therefore do not apply to employee physical therapists who are paid on a fee-for-service basis.

The Board finds that 42 U.S.C. § 1395x(v)(5)(A) and 42 C.F.R. § 413.106 provide no basis for the application of the Guidelines to the employee physical therapists. Both the legislative and regulatory history of the Guidelines indicate that their purpose was to curtail and prevent perceived abuse in the practice of outside physical therapy contractors. The Board also notes that the term "under arrangements" is commonly referred to and used interchangeably with the term "outside contractor."

The Board finds that the regulations and manual were changed in 1998 to include the application of the Guidelines to employees who were paid on a fee-for-service basis. However, since the Provider's cost report period was prior to the regulation and manual changes, the Board finds that the guidelines do not apply to the Provider's cost report period under review.
With regard to the prudent buyer concept, the Board notes that the Intermediary used the prudent buyer concept as a limit, indicating that if the Provider exceeded the limit or guidelines their costs were unreasonable. The Board finds that under this argument the Intermediary claims that the Provider was over the Guideline limit and therefore was not a prudent purchaser of services. The Board finds that the actual variance between the Guideline and the Provider's cost was only 2.04%. The Board finds that this amount of variance is demininus and not substantially out of line.

The Board finds that while the Intermediary argued the prudent buyer concept, the Board finds a lack of appropriate methodology and evaluation. It is the Board's opinion that the Intermediary should have used a method other than that of comparing the costs of the Provider employee therapists to the Guidelines. Instead, the Intermediary should have determined whether the Provider's costs were "substantially out of line" by comparing the Provider's costs to other similar situated providers, pursuant to the regulation at 42 C.F.R. § 413.9.

The Board notes that this case is similar to the All Care case. The Board sees no regulation or manual revision which would require a different holding in this case. Therefore, the Board finds for the Provider. The Provider is entitled to the amount of physical therapy cost in contention.

The Board notes the Intermediary's comments concerning the Worksheet A-8-3 fixed rates for salary and travel allowance. The Board finds no evidence to support their arguments.

DECISION AND ORDER:

The Intermediary's adjustment subjecting the compensation of employed physical therapists, paid on a fee-for-service basis, to the physical therapy guidelines was not proper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: August 8, 2001

FOR THE BOARD

Irvin W. Kues
Chairman