PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2012-D22

PROVIDER –
Lemuel Shattuck Hospital
Jamaica Plain, MA

Provider No.: 22-2006

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

DATE OF HEARING –
October 31, 2011

Cost Reporting Periods Ended –
June 30, 2003; June 30, 2004 and
June 30, 2005

CASE NOs.: 08-1580, 10-0178 and
10-0179

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ISSUE: Whether the allocation of the physician costs between Part A and Part B was proper.[1]

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 under Title XVIII of the Social Security Act, as amended (Act),[2] to provide health insurance to the aged and disabled. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA),[3] 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 to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[4] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[5]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare.[6] Each 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).[7] 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 receipt of the NPR.[8]

The Medicare program is comprised of two complementary programs, the Hospital Insurance program (Part A), which generally pays for hospital care and the Supplementary Medical Insurance program (Part B), which pays for physician, diagnostic and ambulatory services. In reimbursing provider-based physician services,[9] Congress required the Secretary to issue regulations that distinguish physician professional services to individual patients, that are reimbursed under Part B, from those physician services that are rendered for the general benefit of patients in a hospital and are reimbursed as part of the hospital's reimbursement under Part A.[10] Congress allowed hospitals with approved teaching programs to elect to be paid on a reasonable cost basis for physician direct medical and surgical services furnished to its Medicare patients and for the supervision of interns and residents provided that all the physicians in the

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[1] Regarding PRRB Case No. 08-1580, the Provider withdrew the following issue: "Whether the Intermediary's adjustments to exclude inpatient Part B days when the patients received no outpatient services from the count of inpatient Part B days were proper." *See* Transcript (Tr.) at 6 and correspondence dated January 30, 2012 from the Provider's representative to the Board.

[2] 42 U.S.C. Ch. 7, Subch. XVIII.

[3] In 2001, the agency name was changed from CMS to HCFA. For simplicity, this decision generally will use CMS to refer to the agency.

[4] FIs and MACs are hereinafter referred to as intermediaries.

[5] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[6] *See* 42 C.F.R. § 413.20.

[7] *See* 42 C.F.R. § 405.1803.

[8] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

[9] Physicians are considered "provider-based" if they receive compensation from the provider for services furnished in the provider. *See* 48 FR 8902, 8904 (Mar. 2, 1983).

[10] *See* § 1887(a)(1), 42 U.S.C. § 1395xx(a)(1).

hospital agree not to bill Medicare for their services.[11]

The regulations governing provider-based physician services are found at 42 C.F.R. Part 415 and are divided into the following five subparts:

Subpart A-General Provisions
Subpart B-Fiscal Intermediary Payments to Providers for Physician Services
Subpart C-Part B Carrier Payments for Physician Services to Beneficiaries for Providers
Subpart D-Physician Services in Teaching Settings
Subpart E-Services of Residents

Subpart B sets forth rules in determining Medicare payments to providers for physician services to the provider. Within, Subpart B, 42 C.F.R. § 415.60 describes the requirement that providers allocate the compensation costs of physicians "in proportion to the percentage of total time that is spent in furnishing each category of services." Subpart D sets forth specific rules in determining payment for physician services in teaching settings. Within Subpart D, 42 C.F.R. § 415.160 describes an election that teaching hospitals may make to receive payment on a reasonable cost basis for its physician services, and 42 C.F.R. § 415.162(j) specifies that, in determining reasonable costs under that election, the teaching hospital must allocate the compensation costs of its physicians "to the full range of services implicit in the physician compensation arrangements."

CMS publishes the Provider Reimbursement Manual (PRM) CMS Pub. 15, Parts 1 and 2 (PRM 15-1 and PRM 15-2 respectively), that contains guidelines and policies to implement the Medicare regulations. Specific to the instant case, PRM 15-1 § 2148 addresses program reimbursement for a teaching hospital that elects to receive reimbursement on a reasonable cost basis for the direct medical and surgical services of its physicians as set forth in 42 C.F.R. § 415.160 (which is located in 42 C.F.R. Part 415, Subpart D). PRM 15-2 § 3626 provides instructions for the completion of Worksheet (W/S) D-9 Apportionment of Cost for Services of Teaching Physicians for teaching hospitals that make the election described in PRM 15-1 § 2148.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Lemuel Shattuck Hospital, (Provider) a teaching hospital located in Jamaica Plain, Massachusetts, elected to receive Medicare program reimbursement on a reasonable cost basis for its provider-based physician services. The cost reporting periods at issue are the Provider's fiscal years ending on June 30, 2003, June 30, 2004, and June 30, 2005 (FYs 2003, 2004, and 2005).

For FYs 2003, 2004, and 2005, National Government Services, Inc. (Intermediary) determined that the Provider did not have physician allocation agreements and that the Provider's physician time studies were insufficient to support the allocation of physician compensation between Part A and Part B physician services. The Intermediary proposed a preliminary adjustment to report

[11] *See* § 1861(b)(7) of the Act, 42 U.S.C. § 1395x(b)(7).

Part B compensation allocation as zero. The Provider submitted additional documentation including an analysis of Relative Value Units (RVUs) for those physicians lacking a time study. An average RVU percentage was calculated and the Intermediary adjusted the physician compensation for Part B services using that percentage for those physicians lacking an acceptable time study.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 to 405.1840. The Provider was represented by Sean Huse, Associate Manager of Public Consulting Group. The Intermediary was represented by L. Sue Andersen, Esq. from the BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

The Provider disputes the Intermediary's methodology of using RVUs to derive Part B physician compensation and asserts that it is invalid because, as a public institution, they are a nominal charge provider.[12] Consequently, the charge capture was not a priority and any RVU data derived from these charges would never come close to representing actual direct service time of the physicians. Instead, the Provider recommends that the Board apply the time studies according to physician specialty from the cost reporting period ending June 30, 2009.[13] The Provider asserts that, although these time studies are dated up to six years after the cost reporting periods at issue (*i.e.*, FYs 2003, 2004, and 2005), they are nonetheless representative of the periods at issue because there were no major changes to management and duties, bed size, or service delivery area. Alternatively, the Provider urges the Board to consider the average allowable Part B percentages, based on publicly available data obtained from CMS for teaching hospitals located in Massachusetts, the same location as the Provider.[14] Lastly, the Provider contends that pending any other method, and in lieu of allocation agreements, the regulations at 42 C.F.R. § 415.60(f)(2) permit the allocation of 100% of Part B physician cost.[15]

The Intermediary responds that 42 C.F.R. § 415.60 is not applicable to this case because the Provider has acknowledged that, as a teaching hospital, it elected to receive Medicare reimbursement on a reasonable cost basis in lieu of fee schedule payments for physician services furnished to Medicare beneficiaries.[16] The regulations that specifically address reimbursement for physician services in teaching hospitals are 42 C.F.R. §§ 415.160 and 415.162 which are located in 42 C.F.R. Part 415, Subpart D. The regulation 42 C.F.R. § 415.162(j)(2) requires that the allocation of compensation paid to physicians in a teaching hospital must be substantiated on the basis of the proportion of each physician's time spent furnishing each type of service. The Intermediary advised that the Provider did not furnish the allocation agreements, and instead submitted physician time studies to substantiate the allocation of physician compensation. The Intermediary contends that the Provider's documentation was insufficient because time studies were missing up to 70% of the staff physicians.[17] The Provider was permitted to submit billing

[12] Tr. at 13.
[13] Provider Post-hearing brief at 6 - 7.
[14] Provider Post-hearing brief at 9 - 11.
[15] Provider Final Position Paper at 8; Tr. at 20 – 21.
[16] Intermediary Final Position Paper at 7; Provider Final Position Paper at 6; Tr. at 10, 22 – 24.
[17] Intermediary Final Position Paper at 3 – 5; Tr. at 25.

information for those physicians lacking a time study. Based on the RVU data derived from this billing information, an average RVU percentage was calculated and applied to those physicians for whom no acceptable time records were submitted.[18] The Intermediary asserts that the adjustment should be upheld as it is based on the auditable and verifiable data.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has reviewed and considered Medicare law and guidelines, the parties' contentions and the evidence, including stipulations contained in the record. Set forth below are the Board's findings and conclusions.

The Provider is a teaching hospital. This case centers around the Provider's election as a teaching hospital under 42 C.F.R. § 415.160 to be paid on a reasonable cost basis for physician services furnished to Medicare beneficiaries in lieu of being paid under the Medicare physician fee schedule. As part of the process for determining the reasonable cost, 42 C.F.R. § 415.162(j) specifies that the physician compensation must be allocated and that this allocation must "be capable of substantiation":

> (j) *Allocation of compensation paid to physicians in a teaching hospital.* (1) In determining reasonable cost **under this section**, the compensation paid by a teaching hospital . . . to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. . . .
> (2) This allocation must be made and must be capable of substantiation on the basis of proportion of each physician's time spent in furnishing each type of service to the hospital or medical school.[19]

Section 415.162 is located in Subpart D of 42 C.F.R. Part 415. However, neither § 415.162 nor Subpart D specify how an allocation "must be capable of substantiation." In particular, it does not contain any requirements relating to the use of physician allocation agreements. Further, § 415.160(j) does not contain any cross references to any other part or subpart, including Subpart B.

The Provider contends that the allocation rules in § 415.60 are applicable to the case. Section 415.60 is located in Subpart B of 42 C.F.R. Part 415 and addresses reimbursement of physician services to providers. Similar to § 415.160, § 415.60 requires hospitals to allocate physician compensation across the types of physician services in order to determine what portion of such compensation is for physician services to the provider. Unlike § 415.160, § 415.60 provides more specific guidance on the type of documentation required to support an allocation for purposes of reimbursement of physician services to providers. In this regard, § 415.60 states in pertinent part:

> (f) *Determination and payment of allowable physician*

[18] Intermediary Final Position Paper at 6; Intermediary Exhibit I-7.
[19] (Emphasis in original.)

> *compensation costs*. (1) Except as provided under paragraph (e) of this section, the intermediary pays the provider for these costs only if—
> (i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends in furnishing physician service to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and
> (ii) The compensation is reasonable in terms of the time devoted to these services.
> (2) In the absence of a written allocation agreement, the intermediary assumes, for purposes of the provider, that 100 percent of the physician compensation cost is allocated to services to beneficiaries as specified in paragraph (b)(2) of this section.
> (g) *Recordkeeping requirements*. . . . [E]ach provider that claims payment for services of physicians under this subpart must meet all of the following requirements:
> (1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier.
> (2) Report the information on which the physician compensation allocation is based to the intermediary or the carrier on an annual basis and promptly notify the intermediary or carrier of any revisions to the compensation allocation.
> (3) Retain each physician compensation allocation, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.[20]

Regarding the applicability of § 415.60 to this case, the Provider specifically argues that, since no allocation agreements were submitted in this case, § 415.60(f)(2) by its terms applies to this case and that 100% allocation of its Part B physician compensation cost is allowed. The Board disagrees. As previously discussed, § 415.160(j) by its terms is specific and exclusive. Notwithstanding, in parsing through § 415.60, it is also clear that, by its terms, § 415.60(f)(2) does not apply to teaching hospitals that have made election to be paid on a reasonable cost basis in lieu of payments under the physician fee schedule. Specifically, § 415.60(f)(2) applies only to services defined in subsection (b)(2) which in turn is defined as physician services to patients as described in § 415.102, and § 415.102 is limited to "fee schedule payment for physician services to beneficiaries," *i.e.*, payment *under the physician fee schedule*.[21]

Notwithstanding the fact that § 415.60 is not directly applicable to § 415.160, the Board recognizes that there are parallels between the two sections as both concern allocation of

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[20] (Italics in original.)
[21] Further, the discussion in the preamble to the rulemaking published at 48 Fed. Reg. 8902, 8911 (Mar. 2, 1983) discusses the purpose for § 415.60(f)(2) and confirms that the Provider's interpretation would be contrary to that purpose.

physician time and compensation for purposes of reimbursing a particular type of physician service — physician services to providers versus physician services to patients in a teaching hospital when a reasonable cost election has been made.[22] As § 415.60 has greater specificity on what documentation is needed to support an allocation, the Board reviewed § 415.60 for guidance on what may be acceptable documentation to support such an allocation.

CMS promulgated § 415.60 as part of the final rule published on March 2, 1983.[23] As part of its review of § 415.60, the Board reviewed CMS' policy statements in the preamble to the final rule for guidance in determining what type of documentation is acceptable to support the allocation of physician compensation. In the preamble to this final rule, CMS responded to comments regarding documentation and allocation agreements indicating that allocation agreements are based on "reasonable estimates" or "estimated prospective calculation", which can be done on an individual physician *or* department basis:

> *Comment*: Commenters asked several questions about the documentation and preparation of allocation agreements. Some inquired whether they must be prepared prospectively, or whether they could be retroactively based on actual time worked. Commenters also wanted to know what sort of time studies or records would be accepted as a basis for agreements.
>
> *Response:* The allocation agreement should be prepared prospectively, although historical records may be the basis of the estimated prospective calculation. If an estimate becomes unacceptable to the provider or physician on the basis of later experience, they may revise the agreement. Generally, this would occur where the volume of services changes, there is a change in the number of physicians who practice in the department or there are other factors that substantially affect the operation of the department. The intermediary must be notified promptly of all such revisions. Generally, the allocations should be based on a reasonable estimate of the manner in which physicians (considered either as individuals or as a department) spend time. If the allocation of time in a particular case is atypical, or if the allocation does not appear to reflect an understanding of the manner in which physicians' services are covered under Medicare, the intermediary should request time studies or other

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[22] The Board recognizes that, in a situation where a teaching hospital is seeking reasonable cost reimbursement for physician services to providers (Subpart B) and physician services to beneficiaries (Subpart D), both § 415.60 and § 415.160 would both be applicable. However, in this case, the Provider is only seeking reasonable cost reimbursement under § 415.160 because any physician services to the Provider were reimbursed as part of Medicare payments to the Provider under the prospective payment system. *See* PRM 15-1 § 2182.3 ("Note: If a provider is not seeking reasonable cost reimbursement for costs incurred in compensating provider-based physicians for services *to the provider*, an allocation agreement is not required." (Emphasis added.)). *See also* 48 Fed. Reg. at 8907.

[23] 48 Fed. Reg. 8902 (Mar. 2, 1983).

documentation for verification.[24]

CMS also discussed whether using effort reports to validate physician compensation is acceptable, concluding that, effort reports are not acceptable as documentation, since effort usually cannot be quantified as can time. However, an intermediary can accept effort reports if the resulting reimbursement will not differ significantly."[25] The following comment and response contains the additional discussion on effort reports:

> *Comment*: Some hospitals have commented that the National Institutes of Health, in the administration of grants, require effort reports while Medicare requires time allocation reports. They contend that effort reports should be acceptable for use by Medicare.
>
> *Response*: It has been Medicare policy that time, not effort, should be the basis for determining payments for the services of physicians because time can be quantified, effort cannot. Further, section 1887(a)(2)(A) of the Act specifies that costs must be apportioned on the basis of time actually spent by a physician in furnishing services to the provider. However, effort reports may be used by a hospital and its physicians if the intermediary and carrier determine that Medicare payments will not differ significantly by use of effort reports, i.e., that in the individual case, effort can be equated to time. If the intermediary determines, however, that there is a difference between reported effort and actual time that affects Medicare payments, time reports must be used.[26]

CMS also discussed situations when allocation of all compensation can be assumed:

> **B. Assumed Allocation of All Compensation to Patient Services**
> Many, if not all, compensated physicians have some administrative and supervisory responsibilities related to services they furnish in a provider, but in many cases these services do not constitute a significant or measurable portion of a physician's activities. In these cases, the physician's compensation is almost entirely related to services he or she furnishes to individual patients, rather than to services to the provider. For the many physicians who spend, for example, less than 10 percent of their time on such services to the provider, the difficulty of identifying those services and documenting the time devoted to them may be excessive considering the relatively small amount of compensation cost that would be allocated to those services.

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[24] *Id.* at 8910 (italics in original and underline emphasis added).
[25] *Id.*
[26] *Id.* (italics in original and underline emphasis added).

> Therefore, if a provider and a compensated physician agree that the amount of compensation attributable to services that the physician furnishes to the provider is negligible, such as 10 percent or less of the compensation, they may omit furnishing an allocation agreement, so long as the provider claims no cost for such services. We will assume that 100 percent of the services of the physician are services to individual patients that are reimbursable on a reasonable charge basis under Part B.[27]

This discussion suggests that a 10% or less variability is not significant and that time allocation is not an exact science. This is similar to the above discussion of allocation agreements being based on "reasonable estimates" or "estimated prospective calculation" which can be done on an individual physician *or* department basis.

The Board also considered CMS manuals in determining what type of documentation is acceptable in validating the allocation of physician compensation. In particular, PRM 15-1 § 2182 addresses "Services of Physicians in Providers" and, in § 2182.3(E),[28] it discusses the acceptability of allocation agreements:

> In determining whether these [allocation] agreements are acceptable, the intermediary, for example, also considers its knowledge of the providers and the experience gained about them in the administration of its private business. *If necessary, the carrier and the intermediary may impose an allocation, based on experience in other hospitals, until an acceptable agreement is approved.* If the hospital or its physicians disagree with an imposed allocation, the matter is referred to the regional office.[29]

Thus, § 2182.3(E) allows an intermediary to impose an allocation based on experience in other hospitals until an acceptable allocation agreement is approved.

In this case, the Intermediary determined that 70% of the Provider's physicians were lacking valid time studies. In determining a reasonable cost estimate, the Intermediary accepted the time records of the 30% of the physician's with valid time studies. For the 70% of physicians lacking a valid time study, the Intermediary allowed the Provider to submit a time analysis based on the RVU data derived from the Provider's billing information. The Intermediary also used an overall hospital percentage of procedure codes for all inpatient services in the Provider's facility. Based on these factors, the Intermediary calculated that approximately 22% of the Provider's Part B physician compensation was attributed to direct physician services.[30]

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[27] *Id.* (bold in original)
[28] PRM 15-2 § 3626.1 col.6 Supplemental W/S D-9 cross-references to PRM 15-1 § 2182.3E regarding the recordkeeping requirements for allocation of physician compensation.
[29] PRM 15-1 § 2182.3E3 (emphasis added).
[30] Tr. at 46-47; Intermediary Position Paper: Closing Argument at 8 and 9; Intermediary Exhibits I-17 and I-20.

The Board finds that the RVU methodology adopted by the Intermediary is flawed and that the resulting allocation of Part B physician costs is improper. The RVU analysis results in an estimate that approximately 20% of physician time is involved in direct patient care. These results are markedly lower than what the Provider claimed and there is evidence in the record suggesting that some of the physicians at issue were compensated only for direct patient care (*i.e.*, 100% for part B services).[31]

Moreover, the results are markedly lower than the allowable Part B percentages from other teaching hospitals in the same state during the same cost reporting periods as the Provider. Specifically, as derived from CMS data from the Healthcare Cost Report Information System (HCRIS), the allowable Part B percentages for Massachusetts teaching hospitals for cost reporting periods ending 6/30/2003, 6/30/2004, and 6/30/2005 were 56%, 70%, and 68% respectively.[32] The Board finds the data from the other teaching hospitals in Massachusetts probative as it is based on CMS HCRIS data from the same cost reporting periods at issue for similarly-situated hospitals in the Provider's state.

The Provider recommended that the data from physician time studies from the cost reporting period ending June 30, 2009 be applied to those physicians lacking a time study during the cost reporting periods at issue. The Board declines the Provider's recommendation because the data is not contemporaneous to the periods at issue. Instead, consistent with PRM 15-1 § 2182.3E, the Board finds that, in the absence of an allocation agreement, an allocation based on other hospitals may be applied. The Board finds the best available data is from CMS relating to other teaching hospitals in Massachusetts. As discussed above, this data is reliable in demonstrating average allowable Part B percentages as it is based on CMS data of similar teaching hospitals located in the Provider's locale and relevant to the cost reporting periods at issue.

DECISION AND ORDER:

The Intermediary's allocation of the physician costs between Part A and Part B was improper. For each of the cost reporting periods at issue, the Intermediary is to apply the average allowable Part B percentages of teaching hospitals in Massachusetts for that same cost reporting period. The Intermediary's determination is modified.

[31] *See* Intermediary Exhibit I-23 (while there is no allocation in this example, the contract is only for certain specified procedures and compensation is on "per procedure" basis according to the Medicare physician fee schedule).
[32] Provider Post Hearing Brief at 9-11.

BOARD MEMBERS PARTICIPATING:

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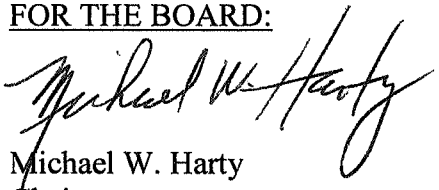

Michael W. Harty
Chairman

DATE: AUG 10 2012