PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D28

PROVIDER –
Cedars – Sinai Medical Center

Provider No.:
05-0625

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions c/o Cahaba Safeguard (J-E)

HEARING DATE –
September 17, 2020

Cost Reporting Period Ended –
June 30, 2009

CASE NO.
16-2292

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ISSUE STATEMENT:

Whether the reasonable compensation equivalent ("RCE") limits should have been applied at all to pre-transplant time spent by physicians working for the Provider *on organ acquisition-related activities* and, if the RCE does apply, whether the Medicare Contractor has applied the wrong RCE limit in its calculation for fiscal year ("FY") 2009.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") makes the following findings in connection with FY 2009 cost report for Cedars – Sinai Medical Center ("Cedars" or "Provider"):

1. The Medicare Contractor properly applied an RCE limit to physician salaries for pre-transplant organ acquisition services on Cedars' FY 2009 Cost Report; and

2. The Medicare Contractor used the incorrect RCE limit in the original adjustments.

Accordingly, the Board remands this appeal to the Medicare Contractor to determine, and apply, the correct RCE limits, based upon the specific physician specialties, and to adjust Cedars' FY 2009 cost report accordingly.

INTRODUCTION:

Cedars, a short-term acute care hospital, is located in Los Angeles, California and operates a Medicare Certified Organ Transplantation center ("CTC"). During the cost reporting period at issue, the Medicare contractor[2] assigned to Cedars was Noridian Healthcare Solutions, LLC ("Medicare Contractor").[3] The costs for a CTC are reimbursed by Medicare on a reasonable cost basis and not under the Inpatient Prospective Payment System ("IPPS").

During the audit of Cedars' FY 2009 cost report, the Medicare Contractor reduced the Kidney acquisition salaries to reflect the application of the RCEs. Cedars appealed the adjustments to the Board, stating that they should be reimbursed for all physician costs related to the transplant services, and that the Medicare Contractor incorrectly reduced the physician costs by applying the RCE limit. [4]

Cedars has timely appealed the issue to the Board, and has met the jurisdictional requirements for a hearing. The Board conducted a Live Video hearing on September 17, 2020.
Cedars was represented by Jordan Keville, Esq. of Davis Wright Tremaine LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services.

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[1] *See* Transcript ("Tr.") at 5.
[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[3] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 1 (Apr. 25, 2018).
[4] Provider's Final Position Paper (hereinafter "Provider's FPP") at 8 (Dec. 20, 2019).

STATEMENT OF FACTS:

The Medicare program has established policies which support organ transplantation by providing payment for the variety of organ acquisition services required to support quality transplant programs. There are two components of the payment made to a hospital designated as a CTC – a prospective payment system payment based on the Diagnostic Related Groups ("DRG") for the services/discharge related to the actual transplant of the organ into the recipient ***and*** an acquisition payment for the reasonable and necessary costs associated with acquiring the organ (*i.e.*, organ acquisition costs).[5]

This appeal focuses on the reimbursement for organ acquisition costs. CTCs are reimbursed on a reasonable cost basis for organ acquisition costs.[6] Cedars employs and pays physicians to perform pre-transplant organ acquisition services and seeks reimbursement from Medicare for the costs of those physicians' salaries. Cedars describes the pre-transplant organ acquisition services as follows:

> THE WITNESS: Well, with respect to organ acquisition costs, . . . the majority of that cost from a physician perspective is related to pre-transplant evaluations, for both donors and recipients. You know, again, determining clinical criteria and patient selection, those who are appropriate to be listed with the OPO for organ candidacy. So that -- that is the heart of it. And -- and in addition, most of them are surgeons, as we touched on, so they are doing the actual organ acquisitions for cadaver acquisitions. You know, the unfortunate circumstances typically are an emergency case and organ donors, and so the -- the surgeons are -- are facilitating and performing those acquisitions in the hospital for the cadaver acquisition. In our case, our -- our physician teams also are utilized by the OPO to do field acquisitions. So our faculty physicians will at times go out into the field at the request of the organ procurement organization and do the acquisition at other facilities. So I would say that the actual acquiring of the organs and the pre-transplant evaluation process for donors and recipients is the heart of the activity that a physician will do with respect to pre-transplant acquisition.
>
> MR. KEVILLE: Okay. So just for purposes of clarity in the record, I'm going to repeat what you just said, or -- or ask a couple of follow up questions. So there can be two different ways an organ is procured for transplant. One, you can have a deceased or cadaver donor from where the organ comes from, and there's also living donors in the case of some types of transplants, correct?

[5] 42 C.F.R. § 412.2(e)(4).
[6] *Id.*

THE WITNESS: Correct.

MR. KEVILLE: And so you said that in the case of deceased donors the organ acquisition physicians will actually perform the excision and remove the -- the organ from the cadaver, correct?

THE WITNESS: Correct.

MR. KEVILLE: And then is also part of that process inspecting your organ once it's removed and making sure that it is actually suitable for transplant?

THE WITNESS: Oh, of course. . . . that is part of sort of the -- the clinical challenges and the -- the expertise and sort of the specialty practice of medicine involved in -- in this field. There are very difficult decisions that require, you know, years of training and experience and specialty. So, of course, yes, part -- part of that process is obviously making the determination whether an organ is viable.

MR. KEVILLE: And -- and when that's done it's -- it's done I guess with the intention of transplanting the organ into an individual who is a patient at Cedars waiting for transplant? Is that correct?

THE WITNESS: That -- that is correct. You know, once the organ acquisition actually occurs it sets in motion the process that we've all seen on TV. We have patients in our program that are on the list. The -- OPO, or the organ procurement organization, is -- is notified and the whole process kicks off. The -- the recipients, you know, make their way to -- to the operating room and to the hospital and -- and the whole process goes from there. Just as a point of clarification, the other way that we get organs obviously is -- is we purchase them directly from the OPO. You know, so -- so sometimes our physicians -- many times our physicians are personally acquiring the organs. In particular, when -- when we have a deceased donor at Cedars- Sinai. Often times the OPO will have our physicians go and acquire the organ for them and -- and in many cases when -- when the OPO has our physicians go and procure an organ at another facility, that is typically because the organ is going to be allocated to Cedars-Sinai for one of our patients. And then in other cases, we are just simply purchasing an organ that is available from the OPO outright. And -- and those organs just come to our center and, you know, again we -- we put in motion the -- the process of the patient coming to the hospital, preparing for OR, and -- and all of that.

> MR. KEVILLE: But even in the case of a purchased organ, I guess the organ acquisition physicians would still be involved in inspecting it prior to transplant. Is that correct?
>
> THE WITNESS: Of course, absolutely there's always going to be a determination of -- of the viability of the organ. And -- and in fact, if we were to ask one of our physicians, they prefer to do the acquisition themselves for that exact reason.
>
> MR. KEVILLE: And then I just want to touch a little bit more on the process for a living donor and -- and how the organ acquisitions would be involved where it's -- it's someone who's actually, you know, alive and providing the organ.
>
> THE WITNESS: Yeah. Well . . . clearly we're really talking about kidney transplants for -- for the living donors. Heart, liver, lung are obviously . . . you're not a living donor. So, yes, I mean that process is also part of work and acquisition. It is -- it is a surgery for -- for the donor, that -- that surgery of acquiring the organ is considered part of organ acquisition. It's -- it is the -- it is part of what we would consider the pre-transplant pool of costs and allowable as a pass through reimbursement on the cost report for the donor. . . .
>
> MR. KEVILLE: . . . . [L]et's focus on organ acquisition. But so even in the case of a living donor for a kidney, it's your organ acquisition physicians that are removing the kidney from the living donor and it's those costs go into the -- the organ acquisition bucket?
>
> THE WITNESS: Yes, typically. Yes.[7]

The Medicare Contractor applied the RCE limits to the pre-transplant related physician salaries on the Medicare cost report. Cedars argues that the RCE limits should not be applied to these salaries.

Cedars argues that organ acquisition activities by physicians cannot properly be considered "services to a provider" for purposes of the RCE limits, as they are services that benefit a particular patient.[8] Cedars' argument continues, "[m]oreover, there are no Medicare statutes, regulations or manual provisions stating (or even otherwise suggesting) that the limits should apply to costs associated with physician organ acquisition activity."[9]

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[7] Tr. at 28-34.
[8] Provider's Post Hearing Brief (hereinafter "Provider's PHB") at 1 (Oct. 31, 2020).
[9] *Id.*

The Board reviewed the key statues and regulations whose interpretations are under dispute in this appeal. First, 42 U.S.C. § 1395x(v)(1)(A) addresses Medicare reasonable costs and states, in pertinent part:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate

> reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

The implementing regulation for determining reasonable costs is found at 42 C.F.R. § 413.9 which states in pertinent part:

> (a) *Principle*. All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under Medicare and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 413.13.
>
> (b) *Definitions*.—(1) *Reasonable cost*. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.
>
> (2) *Necessary and proper costs*. Necessary and proper costs are costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity.

The following portion of the Medicare statute located at 42 U.S.C. § 1395xx(a)(1)-(2) requires that pre-transplant related physician salaries be reimbursed on a reasonable cost basis:

> (1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—
>
> (A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and
>
> (B) which constitute professional services *which are rendered for the general benefit to patients in a hospital* or skilled nursing facility and which may be reimbursed only on a reasonable cost basis or on the bases described in section 1395ww of this title.
>
> (2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.
>
> (B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.
>
> (C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility.[10]

A separate regulation at 42 C.F.R. § 412.100 (entitled "Special treatment: Renal transplantation centers") deals with costs for transplant centers and states:

[10] (Emphasis added.)

> (a) *Adjustments for renal transplantation centers.* (1) CMS adjusts the prospective payment rates for inpatient operating costs determined under subparts D and E of this part for hospitals approved as renal transplantation centers (described at §§ 405.2170 and 405.2171 of this chapter) to remove the estimated net expenses associated with kidney acquisition.
>
> (2) Kidney acquisition costs are treated apart from the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for reasonable expenses of kidney acquisition.

The regulation at 42 C.F.R. § 415.55 establishes the following general payment rules to hospitals for physician services:

> (a) *Allowable Costs*. Except as specified otherwise in 413.102 of this chapter (concerning compensation of owners), 415.60 (concerning allocation of physician compensation costs), and 415.162 (concerning payment for physician services furnished to beneficiaries in teaching hospitals), costs a provider incurs for services of physicians are allowable only if the following conditions are met:
>
> (1) The services do not meet the conditions in § 415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.
>
> (2) The services include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.
>
> (3) The provider has incurred a cost for salary or other compensation it furnished the physician for the services.
>
> (4) The costs incurred by the provider for the services meet the requirements in § 413.9 of this chapter regarding costs related to patient care.
>
> (5) The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in § 415.160, or any other costs incurred in connection with an approved GME program that are payable under 413.75 through 413.83 of this chapter.

> (b) *Allocation of allowable costs*. The provider must follow the rules in 415.60 regarding allocation of physician compensation costs to determine its costs of services.
>
> (c) *Limits on allowable costs*. The intermediary must apply the limits on compensation set forth in 415.70 to determine its payments to a provider for the costs of services.

As referred to in 42 C.F.R. § 415.55(c), 42 C.F.R. § 415.70 specifies the limits on compensation for physician services in providers and states in pertinent part:

> (a) *Principle and scope*. (1) Except as provided in paragraphs (a)(2) and (a)(3) of this section, CMS establishes reasonable compensation equivalency limits on the amount of compensation paid to physicians by providers. These limits are applied to a provider's costs incurred in compensating physicians for services to the provider, as described in § 415.55(a).
>
> (2) Limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective payment system implemented under part 412 of this chapter or to costs of physician compensation attributable to approved GME programs that are payable under §§ 413.75 through 413.83 of this chapter.
>
> (3) Compensation that a physician receives for activities that may not be paid for under either Part A or Part B of Medicare is not considered in applying these limits.
>
> (b) *Methodology for establishing limits*. (1) For cost reporting periods beginning before January 1, 2015. CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty and type of location using the best available data.
>
> (2) For cost reporting periods beginning on or after January 1, 2015. CMS establishes a methodology for determining annual reasonable compensation equivalency limits and, to the extent possible, considers average physician incomes by specialty using the best available data.
>
> (c) *Application of limits.* If the level of compensation exceeds the limits established under paragraph (b) of this section, Medicare payment is based on the level established by the limits.

(d) *Adjustment of the limits*. The intermediary may adjust limits established under paragraph (b) of this section to account for costs incurred by the physician or the provider related to malpractice insurance, professional memberships, and continuing medical education.

(1) For the costs of membership in professional societies and continuing medical education, the intermediary may adjust the limit by the lesser of -

(i) The actual cost incurred by the provider or the physician for these activities; or

(ii) Five percent of the appropriate limit.

(2) For the cost of malpractice expenses incurred by either the provider or the physician, the intermediary may adjust the reasonable compensation equivalency limit by the cost of the malpractice insurance expense related to the physician service furnished to patients in providers.

(e) *Exception to limits*. An intermediary may grant a provider an exception to the limits established under paragraph (b) of this section only if the provider can demonstrate to the intermediary that it is unable to recruit or maintain an adequate number of physicians at a compensation level within these limits.

(f) *Notification of changes in methodologies and payment limits*. (1) Before the start of a cost reporting period to which limits established under this section will be applied, CMS publishes a notice in the FEDERAL REGISTER that sets forth the amount of the limits and explains how it calculated the limits.

(2) If CMS proposes to revise the methodology for establishing payment limits under this section, CMS publishes a notice, with opportunity for public comment, in the FEDERAL REGISTER. The notice explains the proposed basis and methodology for setting limits, specifies the limits that would result, and states the date of implementation of the limits.

(3) If CMS updates limits by applying the most recent economic index data without revising the limit methodology, CMS publishes the revised limits in a notice in the FEDERAL REGISTER without prior publication of a proposal or public comment period.

The primary issue under appeal is whether the RCE limits should be applied to the pre-transplant physician salaries. If the Board determines that the RCE limits do apply to the cost associated with pre-transplant physician services, Cedars believes the appeal should be remanded back to the Medicare Contractor to apply the correct RCE limits to the pre-transplant related physician services.[11] Both the Medicare Contractor and Cedar agree that the incorrect RCE limits were applied to the pre-transplant physician salaries for FY 2009.[12]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Cedars argues that the RCE limits are not applicable to pre-transplant organ acquisition physician services. First, Cedars alleges that, because the RCE limits are not mentioned in any Medicare authority specifically addressing reimbursement for organ acquisition, they do not apply to pre-transplant physician services. Cedars also argues that the RCE limits apply only to services physicians provide directly to a hospital or skilled nursing facility; not to physician services provided directly to a patient. In response, the Medicare Contractor argues that the Medicare regulations require the application of the RCE limits to all pre-transplant physician services.

Cedars first argues that the RCE limits are not referenced in any statutory, regulatory or manual authority specific to organ acquisition or organ transplant reimbursement.[13] The Medicare statute at 42 U.S.C. § 1395xx, grants CMS the authority to establish and maintain RCE limits. It further authorizes CMS to distinguish between, "professional medical services personally rendered by a physician and which contribute to the diagnosis or treatment of an individual patient", and "professional services which are *rendered for the general benefit of patients* in a hospital . . . ."[14] Based on this distinction, Cedars argues that the statute prohibits the imposition of RCE limits on costs associated with physician professional services that benefit individual patients.[15]

Cedars continues with this position by referencing the regulation associated with RCE limits, 42 C.F.R. § 415.70, which states that they "are applied to a provider's cost incurred in compensating physicians for services to the provider. . . ."[16] Cedars argues that, although the regulation does not define "services to the provider," when read in conjunction with 42 U.S.C. § 1395xx, the meaning must be limited to a physician's professional services rendered to generally benefit patients in a facility and not services rendered for the benefit of a specific patient.[17]

Cedars points to commentary to the 1983 Final Rule[18] as support for its conclusion that physician services rendered during organ acquisition are not services to the provider, but rather are services

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[11] The Medicare Contractor applied an RCE limit of $153,400 to all pre-transplant physician services. Cedars argues that the RCE limit for surgery should have been applied since the majority of physicians in question are surgeons and a smaller number are internal medicine. *See* Tr. at 67-68.
[12] Tr. at 13, 67. *See also* Medicare Contractor's Post Hearing Brief (hereinafter "Medicare Contractor's PHB") at 14-15 (Nov. 2, 2020).
[13] Provider's PHB at 4.
[14] 42 U.S.C. § 1395xx(a)(1)(A)-(B) (emphasis added).
[15] *Id.*
[16] 42 C.F.R. § 415.70(a)
[17] *Id.*
[18] 48 Fed. Reg. 8902, 8917 (Mar. 2, 1983).

that benefit individual patients.[19] Cedars notes that, in response to a comment about the scope of the RCE limits, [CMS] responded that, "[t]he limits apply only to physicians who direct a provider department in which the physician's expertise is required or who furnish other services, such as participating in utilization review committee or quality control. . . ."[20] According to Cedars, this indicates that CMS understood "services to the provider" to mean non-clinical, administrative activity by physicians that contribute to the general operation of a facility.[21]

Cedars also references the Provider Reimbursement Manual, Part 1 ("PRM 15-1") § 3101, which governs payment to CTCs for organ acquisition activities, in support of its argument. PRM 15-1 § 3101 states that pre-transplant physician services are a component of total organ acquisition costs.[22] Thus, Cedars concludes that the RCE limit does not apply to pre-transplant physician services because RCE limits are not mentioned in any of the authorities discussing payment to CTCs for organ acquisition activities.

Cedars further asserts that the regulations and manual provisions expressly state that physician costs for all pre-transplant physician services are reimbursable *organ acquisition costs*, without any reference to the RCE limits or other restrictions. Cedars cites 42 C.F.R. § 412.100, which states, in part, "[k]idney acquisition costs are treated ***apart from*** the prospective payment rate for inpatient operating costs, and payment to the hospital is adjusted in each reporting period to reflect an amount necessary to compensate the hospital for ***reasonable*** *expenses* of kidney acquisition"[23] A list of the of allowable kidney acquisition costs is set forth at 42 C.F.R. § 412.100(b) (2009), and the most relevant item to this appeal, at (b)(12), states that the costs of acquiring a kidney (whether from a cadaver or live donor) includes: "[a]ll pre-admission physicians services, such as laboratory, electroencephalography and surgeon fees for cadaver excision, applicable to kidney excision including the cost of physician services."[24] Cedars notes these same principals are listed in PRM 15-1 § 2771, and nowhere are the costs subject to any limit other than being reasonable.[25]

Essentially, Cedars believes that 42 U.S.C. § 1395xx(a)(1)(A)-(B), when read in conjunction with 42 C.F.R. § 415.70(a), means that that the RCE limits only apply to services rendered for the general benefit of patients in a hospital and not for physician services related to the benefit of individual patients.[26] In reaching this conclusion, Cedars relies upon § 1395xx(a)(1)(B) which states that professional services, rendered for the "general benefit of patients in a hospital," must be determined as reasonable based upon a "compensation equivalent to be established by the Secretary in the regulations." To interpret the phrase "general benefit to the patient," Cedars refers to 42 C.F.R. § 415.70, which states, "limits are applied to a provider's cost incurred in compensating physicians for services to the provider."

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[19] Provider's PHB at 4.
[20] *Id.*
[21] *Id.*
[22] *Id.* at 8.
[23] Provider's PHB at 7 (emphasis added).
[24] *Id*.
[25] *Id*.
[26] *Id* at 2.

In response, the Medicare Contractor looks to 42 U.S.C. § 1395x(v)(1)(A), which governs Medicare reasonable costs, and states that the reasonable cost of *any* service shall be the actual cost incurred and excludes any cost found to be unnecessary in the efficient delivery of needed health services. The Medicare Contractor states that 42 C.F.R. § 413.9 implements § 1395x(v)(1)(A) and provides that reasonable costs include all necessary and proper costs incurred in furnishing healthcare services. Specifically, 42 C.F.R. § 413.9(a) states, "[a]ll payments to providers of services must be based on the ***reasonable*** *cost* of services covered under Medicare and related to the care of beneficiaries."[27] The regulation at 42 C.F.R. § 413.9(b)(1) defines reasonable cost as the, "cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included."[28]

The Medicare Contractor also asserts that 42 C.F.R. § 415.55, *absent any exception or exemption*, determines the reasonable cost of ***all*** physician services rendered to providers. The Medicare Contractor notes that none of the exceptions found in § 415.55 apply to the organ acquisition costs of physician salaries.[29] Since none of its exceptions are met, 42 C.F.R. § 415.55(c) requires that "[t]he intermediary must apply the limits on compensation set forth in 415.70 to determine its payments to a provider for the costs of services."[30]

The rules for limiting physician costs for services to a provider, through the RCE limits, are set forth at 42 C.F.R. § 415.70. Specifically, 45 C.F.R. § 415.70(a) states that RCE limits, "are applied to a provider's costs incurred in compensating physicians for services to the provider *as described in § 415.55(a)*."[31] There are exceptions for the "costs of physician compensation attributable to furnishing inpatient hospital services that are paid under the prospective payment system . . . or to costs of physician compensation attributable to approved GME programs. . ." or physician compensation that "may not be paid for under either Part A or Part B of Medicare. . . ."[32] CMS applies a methodology for "determining annual reasonable compensation equivalency limits. . ." and applies those limits if "the level of compensation exceeds the limits established. . . ."[33] In this case, the Medicare Contractor determined that the salaries of the physicians performing pre-transplant services failed to meet either of the exceptions in paragraph (a)(2) or (a)(3).[34] As a result, the Medicare Contractor made adjustments to Cedars' cost report to limit Cedars' physicians' salaries related to pre-transplant services.[35]

The Board finds Cedars' interpretation of the statutory phrase "general benefit to the patient" in 42 U.S.C. § 1395xx(a)(1)(A)-(B) to be strained. When read by itself, this provision clearly states that physician services related to the benefit of a patient *must* be evaluated for reasonableness. The only exception is for physician services that result in a diagnosis ***and*** *are paid under Part B*. Thus, any services ***not*** paid under Part B *must* be evaluated for reasonableness. The phrase "services to the provider" in 42 C.F.R. § 415.70 can mean physician services paid by the

[27] (Emphasis added.)
[28] Medicare Contractor's PHB at 7.
[29] *Id.* at 8.
[30] 42 C.F.R § 415.55
[31] (Emphasis added.)
[32] 42 C.F.R. § 415.70(a)(1).
[33] 42 C.F.R. § 415.70(b)-(c).
[34] Medicare Contractor's PHB at 10.
[35] *Id.*

provider (hospital) and related to the general benefit of patients. This would include the physician's administration of a department, pre-organ acquisition costs, *etc*. and, importantly, the pre-transplant organ acquisition physician services are ***not*** *performed for the benefit of the potential organ* ***donor*** (*i.e*., the individual patient from which the organs are acquired)[36] but rather for the benefit of the general patient population of the potential recipients for whom the acquired organs are intended to be available and benefit.[37] Indeed, this conclusion is further supported by the fact that some pre-transplant organ acquisition services do not entail furnishing services to a living individual or patient but involve cadavers since some organs are harvested from cadavers.

These reasonable cost limits are applied to a provider's costs incurred in compensating physicians for services to the provider, as described in § 415.55(a). The Board notes that 42 C.F.R. § 415.70 states the RCE limits, "are applied to a provider's costs incurred in compensating physicians for services to the provider, *as described in § 415.55(a)*."[38] The description of physician services that are subject to the RCE limits are listed in 42 C.F.R. § 415.55(a)(1) through (5) as follows:

> (1) The services do not meet the conditions in § 415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.
>
> (2) The services include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.
>
> (3) The provider has incurred a cost for salary or other compensation it furnished the physician for the services.
>
> (4) The costs incurred by the provider for the services meet the requirements in § 413.9 of this chapter regarding costs related to patient care.
>
> (5) The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in

[36] The pre-transplant organ acquisition services are not being performed to treat or diagnose the potential organ ***donor***, *i.e*., the individual patient from which organs may be acquired. Indeed, to this end, pre-transplant organ acquisition services are *not* generally a billable event for the individual from whom an organ may be potentially acquired because they are a ***donor***.

[37] Maintaining an availability of viable organs benefits the general patient population who may need an organ transplant and pre-transplant services are not necessarily being performed for an identified or identifiable organ recipient. Acquired organs are associated with a pool that benefits not just patients of Cedars but also patients at other facilities outside of Cedars, potentially not just regionally but nationally. To this end as explained in PRM 15-1 § 3100, "[t]o participate in the Medicare program, a certified transplant center (CTC) or organ procurement organization (OPO) must be a member of the Organ Procurement and Transplantation Network (OPTN)."

[38] (Emphasis added.)

> § 415.160, or any other costs incurred in connection with an approved GME program that are payable under 413.75 through 413.83 of this chapter.

The pre-transplant physician services meet these requirements because they: (1) are neither billed nor paid on a fee schedule (2) are not related to physician availability services; (3) are paid by the hospitals; (4) are costs related to patient care[39]; and, (5) are not costs that involve the supervisions of residents. Accordingly, the RCE limits under 42 C.F.R. § 415.70 are applicable to the pre-transplant physician services because they meet all of the requirements of 42 C.F.R. § 415.55(a)(1) through (5).[40]

There are two exceptions to the RCE limits set forth in 42 C.F.R. § 415.70(a)(2) and (3):

> (2) Limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services that are paid for under the prospective payment system implemented under part 412 of this chapter or to costs of physician compensation attributable to approved GME programs that are payable under §§ 413.75 through 413.83 of this chapter.
>
> (3) Compensation that a physician receives for activities that may not be paid for under either Part A or Part B of Medicare is not considered in applying these limits.

Organ acquisition costs are not paid under IPPS, nor are they GME-related, therefore, the exception under (a)(2) is not applicable. However, it is the second exception that is of importance to this appeal. The second exception states that the RCE limits would not be applied if the compensation is "for activities that *may **not** be paid* for under either Part A or Part B of Medicare."[41] While Part B would normally pay the physician fees for services to individual patients, that is *not* the case for the cost of pre-transplant physician services since the pre-transplant organ acquisition services are never being furnished to treat or diagnose the individual patient *from which an organ is (or potentially may be) acquired*.[42] However, pre-transplant physician services *are* reimbursed under Medicare Part A through the Medicare cost report as part of the hospital's operational costs. Therefore, Medicare Part A pays for the pre-transplant organ acquisition services and the exception under (a)(3) is not applicable. This regulation was amended in both 2005 and 2014 and no additional exceptions were added for organ acquisition or pre-transplant services. As a result, the Board concludes that RCE limits *must* be applied to pre-transplant physician services.

Additional support for this conclusion comes from the Provider Reimbursement Manual, CMS

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[39] These costs are peripheral to the diagnosis and treatment of the eventual organ transplant recipients. *See supra* notes 36, 37.
[40] 42 C.F.R. § 415.55 (c) (entitled "*Limits on allowable costs*"). The intermediary must apply the limits on compensation set forth in 415.70 to determine its payments to a provider for the costs of services.
[41] 42 C.F.R. § 415.70(a)(3) (emphasis added).
[42] Moreover, when pre-transplant organ acquisition services are performed on a cadaver, there is clearly no patient.

Pub. 15-2 ("PRM 15-2"), which provides instructions for cost report preparation.[43] In PRM 15-2 § 3615 (instructions for Worksheet A-8-2 on Form 2552-96),[44] a note states: "[t]he adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 5-69, 82-86, and 92 and subscripts as allowed." Similarly, in PRM 15-2 § 4018 (instructions for Worksheet A-8-2 on Form 2552-10),[45] the note is expanded to state "[t]he RCEs are not applied to Medicare non-reimbursable or Medicare non-certified areas of the hospital and the adjustments generated from this worksheet for physician compensation are limited to the cost centers on Worksheet A, lines 4 through 41, 43, 50 through 77, 90 through 99, 105 through 111, and 115, and subscripts as allowed." It is important to note that this change clarified two areas in which RCE limits should not be applied. However, *neither* of these applies to organ acquisition costs (organ acquisition *is* Medicare reimbursable, and further, organ transplant centers *must be* Medicare-certified). Revisions have been made to the cost report instructions in PRM 15-2 to identify situations in which RCE limits should not be applied. However, these revisions make no mention of organ acquisition cost centers being excepted from the RCE limits. In fact, although the cost report forms changed between these two notes, the instructions for the lines to be used for organ acquisition cost centers, clearly state that "adjustments generated from this worksheet . . . are limited to the [organ acquisition] cost centers. . . ."[46] Clearly, the cost report instructions state that *adjustments* will be made to organ acquisition physician costs through this worksheet. Cedars' argument fails to convince otherwise.

The Board disagrees with Cedars' assertion that RCE limits *only* apply to services rendered for the general benefit of patients in a hospital, and not for physician services related to the benefit of individual patients. The Board finds that the numerous statutory and regulatory provisions at issue here cannot be interpreted in isolation, but must be read in conjunction with one another. Specifically, the terms of both 42 C.F.R § 412.100 and 42 U.S.C. § 1395 require that the pre-transplant physician organ acquisition costs must be reasonable. Further, the pre-transplant costs are determined to be reasonable based on the methods as defined in 42 C.F.R. § 413.9. The Medicare statute, at 42 U.S.C. § 1395xx(a)(1)(B)-(2)(B), states that professional services rendered for the general benefit of patients, shall be paid on a reasonable compensation equivalent as established by the Secretary through regulation. Finally, as fully explained above, the regulations at 42 C.F.R. § 415.55 and 42 C.F.R. § 415.70(a) identify the physician services that are subject to the RCE limits. There is *no* exception for pre-transplant physician services from the RCE limits in either of these regulations. Indeed, a close reading of the March 2, 1983 final rule confirms that, from a historical perspective, it is clear that RCE limits were applicable to physician services paid *on a reasonable cost basis* (clinical or nonclinical):

> Allowable compensation for services furnished by physicians to providers that are reimbursable *on a reasonable cost basis* will be subject to limits for Medicare reimbursement purposes. . . . These limits will apply to reasonable costs payable from the Part B trust

[43] In Chapter 36, PRM 15-2 addresses cost reporting Form CMS-2552-96. In Chapter 40, PRM 15-2 addresses cost reporting Form CMS-2552-10.
[44] Used from 1996 – 2010.
[45] In use since 2010.
[46] *See* PRM 15-2 §§ 3615, 4018.

> fund, for CORF and hospital outpatient services, as well as to the costs of inpatient services payable under Part A.
>
> If a physician receives ***any*** compensation from the provider for his or her physician services to providers, *reasonable cost reimbursement* to the provider for the costs of compensation allocated to those services will be limited by the RCE limit. The RCE limits will not be applied to reimbursement for services furnished to individual patients that are reimbursable *on a reasonable **charge** basis* [i.e., payable under Part B], even if the physician agrees to accept compensation (e.g., from a hospital) for those services, *except in teaching hospitals that elect to be reimbursed for such services on a reasonable cost basis in accordance with section 1861(b)(7) of the Act*. If the physician is compensated only for services to the provider, the RCE limit will be applied to reimbursement to the provider *on a reasonable cost basi*s for the entire cost of compensating the physician for those services. (See section V. A. above for the definition of compensation and rules for allocating it among types of physician services.)
>
> The limits apply equally to ***all*** physician services to providers that are *reimbursable on a **cost** basis* under Medicare and for which physicians are compensated by the provider, ***not just to services of radiologists, anesthesiologists, and pathologists***.)[47]

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds that the audit adjustments applying the RCE limits to physician salaries for pre-transplant organ acquisition services were proper. Under Medicare payment policy for organ transplantation costs, reimbursement is available to CTCs for reasonable costs related to physician salaries for pre-transplant organ acquisition services. The Board is not persuaded by (and disagrees with the basis for[48]) Cedars' argument that, because the service was provided to a "patient" and not the "provider," there is any sort of exception to applying the RCE limits. As explained in detail above, although the RCE regulation may be "vague" by Cedars' standards, the pre-transplant physician services are not excluded from the application of the RCE limits under the applicable law and regulations.

Reasonable cost reimbursement does not equate to full reimbursement for a service rendered. RCE limits are imposed to ensure that a provider only pays a reasonable cost for the service provided. If Cedars felt an exception to the RCE limits was warranted, they could have requested relief from those limits, but there is nothing in the record indicating it chose to do so. Nor does it appear that an exception under 42 C.F.R. § 415.70(e) would be granted under the

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[47] 42 Fed. Reg. at 8917 (emphasis added).
[48] *See* Board discussion at *supra* notes 36, 37 and accompanying text.

circumstances in this appeal. Therefore, the Board concludes that RCE limits were properly applied to the physician salary payments, for pre- and post- transplant services.

The remaining issue is *what* RCE limit should be applied. The Medicare Contractor applied the RCE limit for the "Total" category because there is no "organ acquisition physician" category.[49] However, Cedars argues that the majority of the pre-transplant physicians are surgeons and that the surgery RCE limit should be applied.[50] If Cedars is able to provide documentation to support the specialty of each pre-transplant physician, the Medicare Contractor has agreed to apply the appropriate RCE limit to each individual physician based on that physician's specialty RCE limit.[51] If Cedars is not able to provide adequate documentation for each physician, the Total category will be used.

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that:

1. The Medicare Contractor properly applied an RCE limit to physician salaries for pre-transplant organ acquisition services on Cedars' FY 2009 Cost Report; and,

2. The Medicare Contractor used the incorrect RCE limit in the original adjustments.

Therefore, the Board remands this appeal to the Medicare Contractor to determine, and apply, the correct RCE limits, based upon the specific physician specialties, and to adjust Cedars' FY 2009 settled cost report accordingly.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

For the Board:

9/14/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[49] Medicare Contractor's FPP at 26.
[50] *Id.*
[51] The pre-transplant physicians are likely to fall into either the Surgery RCE limit or Internal Medicine RCE limit. *See id.*