PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D6

PROVIDER -Methodist Hospital
St. Louis Park, MN

Provider No. 24-0053

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of
Minnesota

DATE OF HEARING-
September 16, 1997

Cost Reporting Period Ended -
October 31, 1989

CASE NO. 93-0228

INDEX

ISSUE:

Did the Intermediary properly disallow the physician's Part A compensation?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist Hospital ("Provider") is a non-profit, general short term hospital located in St. Louis Park, Minnesota. Blue Cross and Blue Shield of Minnesota ("Intermediary"), disallowed the physician's Part A compensation due to its contention that there was no detail to support the monthly time records. The Intermediary allocated the physician compensation as 100% physician services to patients, thus removing all physician compensation from Part A allowable costs. The Provider disagreed with the Intermediary's adjustments and filed an appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $14,733.

The Provider was represented by Becky Hoffarth, Revenue Manager, Health System Minnesota. The Intermediary was represented by Bernard M. Talbert, Esquire of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the time reports completed and signed by each physician on a monthly basis satisfy the requirement of 42 C.F.R. § 405.481 which states:

> (g) Recordkeeping requirements. Except for services furnished in accordance with the assumed allocation under paragraph (e) of this section, each provider that claims payment for services of physicians under this subpart must:
> (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;. . .

The Provider points out that it has submitted to the Board a copy of a blank time report and a report completed by a physician, which satisfies the requirements of the above-stated regulation.

The Provider explains that these time reports are used as a time card for the physician. If the time report is not turned into payroll, the physician does not get paid. Therefore, the Provider contends that the documentation is adequate and the Intermediary's adjustment should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not meet the recordkeeping requirements of the Medicare regulation at 42 C.F.R. § 405.481. The Provider's records are not adequately supported by actual auditable data accumulated by the Provider during the cost reporting period. Monthly summaries of the provider-based physicians hours do not represent auditable data. The Intermediary further argues that its Medicare Bulletin #193 (dated September 14, 1990)[1] reaffirms policy and requirements for reimbursement of provider- based physicians. Regarding the allocation of time, the bulletin states:

> If no such agreement exists, the intermediary will assume that the physician's compensation is 100 percent physician services to patients. The regulations also state the recordkeeping requirements in 42 C.F.R. § 405.481(g) to be the following:
>
> The Provider must maintain time records or other information used in the allocation of the physicians compensation.

Medicare Bulletin 193.

The Intermediary contends that its Medicare Bulletin #196 (dated December 21, 1990)[2] clarifies Medicare Bulletin #193 as to what are acceptable time records. It states:

> As the September 14, 1990 bulletin indicates, that provider must maintain verifiable time records or other information used to support the allocation of the physician's compensation. This means, according to 42 C.F.R. § 405.481, that verifiable time records must be available to support Part A hours and/or Part A/Part B time splits. Amounts reported in contracts or the HCFA -339 do not suffice as verifiable documentation. Verifiable support may take the form of either daily time reports maintained by the physician or time studies completed by the physician. If time studies are used, the time studies should, at a minimum, be performed two weeks each quarter.

Medicare Bulletin 196.

The Intermediary points out that while these bulletins are dated after the fiscal year under review, it is the Intermediary's contention that these bulletins are clarifications of existing program policy found in 42 C.F.R. §§ 405.480-82 and in HCFA Pub. 15-1 § 2182.3. Therefore, the Intermediary

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[1] Intermediary Exhibit I-2.

[2] Intermediary Exhibit I-2.

contends that the Provider's documentation is inadequate and the cost should be considered 100% Part B physician services to patients.

The Intermediary also points out that its position is supported by Sharp Cabrillo Hospital (San Diego, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec No. 93-D36, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,438 declined rev. HCFA Administrator, June 25, 1993. The Intermediary points out that the Board ruled in that case that 42 C.F.R. § 405.481(g) requires a hospital to submit to its intermediary the information on which its allocation of provider-based physicians' costs is based.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

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

§ 405.480	-	Payment for Services of Physicians to Providers: General Rules
§ 405.481	-	Allocation of Physician Compensation Costs
§ 405.482	-	Limits on Compensation for Services of Physicians in Providers

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

§ 2182.3	-	Allocation of Physician Compensation

4. Cases:

Sharp Cabrillo Hospital (San Diego, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 93-D36, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,438 declined rev. HCFA Administrator, June 25, 1993.

5. Other:

Blue Cross and Blue Shield of Minnesota Bulletin #193, September 14, 1990
Blue Cross and Blue Shield of Minnesota Bulletin #196, December 21, 1990

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows: the Provider maintained monthly time reports to allocate physician time between Part A services and Part B services. These records were used for payroll purposes. The Board notes that if the Provider did not have any time records, the amount allowed by the Intermediary as Part B services would also be unallowable. However, the Intermediary did allow all of the physician's time as Part B cost. Therefore, there must have been a basis upon which the Intermediary compensated the Provider for the Part B services.

The Board finds that although the Intermediary argued that there were no concurrent time studies available as required by the regulation at 42 C.F.R. § 405.481(g), the Board finds that there were time records maintained by the Provider. The Intermediary's own workpapers validated the Provider's time studies. The Intermediary's auditors were able to trace the time studies for the period November, 1988 to October , 1989.[3] On the time report entitled "Physician Time Reports-Part A Hours", there is on the bottom of the time sheet an auditor's notation which states: "denotes ties to time study." In addition, on the next page of the Intermediary's position paper is a time report of one of the physicians.[4] This time report was traced by the Intermediary's auditor to the form "Physician Time Reports-Part A Hours."

The Board notes that it did not give great weight to the Intermediary's contention that its Medicare Bulletins #196 and #193 clarified the issue as to what constitutes acceptable time records. The Board finds that these Bulletins were prepared by the Intermediary; they are not Blue Cross/Blue Shield Association documents, nor are they HCFA documents. The Bulletins were prepared by the Intermediary for presentation to their Providers. The Board also finds that the bulletins were dated after the cost report period in contention. While MB #196 describes verifiable support as ". . .either daily time reports maintained by the physician or time studies completed by the physician, Intermediary workpapers (see Exh. I-1, workpaper 9B-1.1) states, "[t]he provider does not have daily records of the physician time except for the area of pathology. Therefore, the provider's A-8-2 will be adjusted by moving all provider amounts (except for pathology) to professional." (emphasis added). The Intermediary's conclusion is not substantiated by PRM § 2182.3(E)(4) which states that maintenance of daily logs or time records are not required.

The Board finds that the Intermediary's contention that its position is supported by Sharp Cabrillo Hospital (San Diego, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 93-D36, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,438 declined rev. HCFA Administrator, June 25, 1993, is without merit. The Board finds that the facts in that case are not the same as in the current case.

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[3] Intermediary Exhibit I-1.

[4] Intermediary Exhibit I-1.

The Board finds that there was evidence of an allocation between Part A and Part B physician costs, and, therefore, the adjustment was improper.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the physician's Part A compensation was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman