PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D31

PROVIDER -Ellis Hospital
Schenectady, New York

DATE OF HEARING-
May 23, 1997

Provider No. 33-0153

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

CASE NO. 91-2986M

INDEX

ISSUE:

Were the Intermediary's adjustments made for graduate medical education ("GME") settlement purposes proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Ellis Hospital ("Provider") is a general, short-term hospital located in Schenectady, New York.
It provides medical, surgical, intensive care, and other acute care to patients. It is affiliated with Albany Medical Center ("AMC") which operates its intern and resident program.

As a result of the Comprehensive Omnibus Budget Reconciliation Act of 1985, GME costs are paid on a prospective cost basis effective for cost reporting periods beginning on or after July 1, 1985. A base year cost (1984) had to be determined. For this Provider an audit specifically reviewing those 1984 GME costs was commenced by the Empire Blue Cross and Blue Shield ("Intermediary") in 1990. The Provider is appealing the results of this audit which adjusted both the base year and effectively, the subsequent years ("rate years") which use the approved GME rate.

The Provider challenged three aspects ("subissues") of the Intermediary's determination with respect to graduate medical education reimbursement. First, it disallowed reimbursement for critical care fellows because the program in which the fellows were enrolled purportedly was not approved by the Accreditation Council for Graduate Medical Education ("ACGME"). Second, the Intermediary included 2.18 full time equivalent ("FTE") neurology residents in the base year count as claimed by the Provider in its filed cost report. That resulted in the Provider being denied over half the reimbursement to which it was entitled merely because of a billing convention adopted by another hospital over which the Provider had no control. Third, the Intermediary refused to permit the allocation of overhead costs to the supervising physician cost center because at the time of the GME audit, some six years after the costs were incurred, the Provider no longer maintained records reflecting such costs. The Provider was under no obligation to maintain relevant financial records for more than five years.

Regarding the first subissue, the Provider participated in a critical care fellowship program which was operated under the department of medicine at AMC. The fellows in this program completed the Internal Medicine residency program and stayed on for the two year fellowship in critical care. The internal medicine accreditation for AMC dated June 13, 1984, of which the Provider is an affiliated hospital, indicates that the residency review committee had also reviewed nine subspecialty programs requesting accreditation under the sponsorship of AMC's internal medicine program. Critical Care was not one of the nine programs listed. The nine subspecialty programs would only be considered accredited after all of them had been reviewed (approximately 3-4 years). The critical care fellowships became accredited in 1989.

Regarding the second subissue, the Intermediary was provided a summary schedule on audit in support of the Provider's FTE claim for base year purposes. The source of the information provided was from AMC's monthly billings to the Provider. AMC operated a number of intern and resident programs in which the Provider participated. The Provider paid for its portion of the programs through billings by AMC. The Intermediary selected a sample from the Provider summary and traced the interns and residents back to the Provider's assignment schedules. The neurology residents were not included in the sample testing; therefore, the 2.18 FTEs claimed by the Provider for this program were accepted based on the results of the sample testing. When the Intermediary performed rate year audits for the years 1986-1989, it determined through audit testing that while the Provider was billed for two neurology residents each month, only one of the residents came to the Provider. The other resident remained at AMC. In the rate year FTE counts, the Intermediary only counted the time spent by the neurology residents at the Provider regardless of the information shown on the AMC monthly billings.

Regarding the third subissue, as background, the Intermediary included in the Provider's APRA misclassified direct costs for supervising physicians in the GME count centers for GME base year purposes after documentation was presented to show the same misclassification occurred in the 1982 prospective payment system ("PPS") base year costs. The only indirect costs related to these direct supervisory costs were employee health and welfare because the allocation statistic (gross salaries) could be verified in both the 1984 GME base year and the 1982 PPS base year. However, the Provider did not produce appropriate statistical documentation to show consistent misclassification of other indirect costs between the GME and PPS base years, and therefore, GME costs did not increase for GME base year purposes. The Provider offered to prepare surrogate amounts, but the Intermediary refused to permit the Provider to present this because of the absence of the actual records.

The Provider appealed these three subissues to the Provider Reimbursement Review Board ("Board"). The appeal has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841, and the amount in dispute exceeds $10,000 in reimbursement. The Provider was represented by Thomas S. D'Antonio, Esquire, of Nixon, Hargrove, et. al. The Intermediary was represented by Michael F. Berkey, C.P.A., Associate Counsel for Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that although counsel to the Intermediary attempted to argue differently, the parties all along have understood that in challenging the Intermediary's determination with respect to GME reimbursement, the Provider sought to appeal both the base and rate years determinations. First, the letter by which the Provider initiated the process of Board review specifically addressed the disallowance of critical care residents in rate years 1986, 1987, and 1988. It stated that the costs incurred in connection with critical care training

were being disallowed in rate years as interns and residents in an approved program.[1] In fact even the Intermediary's witness conceded that this appeal letter refers to both rate and base years.[2] Further, the Provider's preliminary position paper also clearly referred to both rate and base years. Indeed, addressing such issues as inconsistent base and rate year resident FTE counts could not logically be contemplated without challenging both the base and rate year determinations. Finally, the extensive settlement negotiations that occurred prior to the hearing contemplated base and rate year challenges.

Regarding the critical care fellows subissue, the Provider contends that the costs incurred with respect to such training between 1986 and 1989 should be reimbursed because that training meets the criteria set forth in 42 C.F.R. § 413.86. The regulation at 42 C.F.R. § 413.86(b) sets forth several alternatives for the reimbursement of such costs, only one of which is accreditation by the ACGME. Specifically, the regulation provides:

> Approved medical residency program means a program that meets one of the following criteria:
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> (1) Is approved by one of the national organizations listed in § 415.200(a) of this chapter.
>
> (2) May count towards certification of the participant if listed in the current edition of either of the following publications:
>
> (i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or
>
> (ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.
>
> (3) Is approved by the Accreditation Council For Graduate Medical Education ("ACGME") as a fellowship program in geriatric medicine.
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> (4) Is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an

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1 See Provider Exhibit A.

2 Transcript ("Tr.") at 261.

> induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

42 C.F.R. § 413.86(b).

The auditors making the adjustments at issue failed to look beyond criterion number 3 when it disallowed the costs relating to the training of the critical care fellows. The Provider contends that the Intermediary does not understand that the theories of reimbursement stated in 42 C.F.R. § 413.86 are alternative and disjunctive, not co-requisite and conjunctive in nature.

The Provider notes that the Intermediary's witness testified that there was no reason to consider any of the alternative theories of reimbursement under § 42 C.F.R. § 413.86 because it disallowed the cost of the FTEs for critical care fellows based on the fact that it was not approved by the ACGME, and therefore, there was no need to take it to another level of review.[3] This is simply wrong. This admission demonstrates unequivocally that the determination to disallow the GME costs at issue was erroneously based on the mistaken notion that ACGME accreditation is the sine qua non of reimbursement. This misconception is dispelled by merely reading the regulation.

The Provider notes that audit workpapers entered into evidence by the Intermediary at the hearing demonstrated rather clearly that the witness' lack of understanding of the regulation was shared by the auditor at the time the disallowance was made. Intermediary Exhibit E, a letter to Dr. Raghavan at AMC from the American Board of Internal Medicine, bears an auditor's note that indicates that because the critical care training at the Provider was not accredited by the ACGME, it was not reimbursable.[4] Further, the Intermediary's witness admitted that the costs were disallowed because they were incurred in connection with a training program not yet accredited by the ACGME, and therefore, there was no need to look further to determine whether the costs were reimbursable. Yet, the regulations make perfectly clear that only one of four alternative grounds must be met in order to obtain reimbursement for GME costs. In this regard, the Provider established that, although critical care training indeed had not yet been accredited by the ACGME in the 1984 base year, the critical care training that occurred in 1984, and in each of the pertinent rate years thereafter, counted toward board certification in critical care medicine, a sub-specialty recognized by the American Board of Internal Medicine. To that end, the Provider offered evidence of the

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[3] Tr. at 232 and 254.

[4] Tr. at 240.

credentials held by Dr. Sophie Socaris,[5] Dr. Ian Cohen,[6] Dr. Vani Mekala,[7] and Dr. William Power,[8] all of whom were critical care fellows at the Provider during the period for which the Provider seeks reimbursement. In fact, one of the Intermediary's own workpapers, which was discussed at the hearing at length[9] demonstrates that Drs. Cohen, Mekala, and Power were all critical care fellows at the Provider in 1984. Provider's Supplemental Exhibit A demonstrates that Dr. Socaris also was a critical care fellow at the Provider between 1985 and 1987. Ross LeBlanc, the Provider's administrative director of medical affairs, testified that the critical care fellowship training received counted toward the credentials conferred upon these individuals by the American Board of Internal Medicine in the subspecialty of critical care medicine.[10]

The Provider argues that the Intermediary did not seriously challenge any of this evidence at the hearing. Instead, it attempted to draw a distinction between "certification," "special qualification," and "subspecialty" that would somehow be relevant to the reimbursement determination. The plain language of the regulation, however, directly undercuts this attempt. The Medicare program, under its regulations, recognized that there would be circumstances when valid graduate medical training would be offered before the ACGME accredited the particular program. Indeed, Mr. LeBlanc testified that such circumstances were common where a "critical mass" in the academic medical community was developing around a progressive concept in medicine.[11] In such circumstances, the costs of these developing programs are reimbursable as long as it can reasonably be established that such training is recognized as a legitimate endeavor by a qualified certifying body such as, in this case, the American Board of Internal Medicine.

Regarding the second subissue, the neurology FTE count, the Provider contends that the base and rate year counts of neurology FTEs must be consistent As the result of an agreement between the Provider and AMC, neurology residents from AMC rotated to the Provider, and the latter paid for these services. Based on a convention adopted by AMC's neurology department that was in effect for some 25 years, the Provider was billed for two residents for each resident that actually rotated to it. The billing for this additional resident, in both the base year and the rate years was designed by AMC to capture the overhead costs associated

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5 Tr. at 50.

6 Tr. at 65.

7 Tr. at 63-64.

8 Tr. at 66.

9 Tr. at 121-128.

10 Tr. at 64-65, 68, 119, 131.

11 Tr. at 53-54.

with each resident. For base year purposes, the bills were paid in the routine course by the Provider, and costs were claimed accordingly. However, during the rate year audits, the Intermediary discovered that only one resident was actually present at the Provider, and it disallowed the count of the second resident.[12] However, the Intermediary left the second resident in the count for the base year.[13] This created an inconsistency between the base and rate year treatment of that issue, and caused the Provider to lose reimbursement for half of the costs it actually incurred with respect to these neurology residents.

The Provider further contends that the payments the Provider paid to AMC were understood to be legitimate charges for administrative and overhead costs, appropriately reimbursable by Medicare.[14] However, because of the convention adopted by AMC's department of neurology, these costs were called into question during the rate year audit. The Provider by this appeal simply seeks to have the counts made consistent, either by continuing to count two residents in the rate years, or by counting only one in the base year. Because the latter resolution more accurately reflects reality, the Provider is proposing that the count be adjusted accordingly in the base year.[15] Whichever manner of achieving consistency that is chosen by the Board, however, it is clear that the Provider should not be denied reimbursement as the result of this billing convention over which it had no control and in which it had no say. The fact remains that the costs incurred were legitimate and reimbursable, and the Intermediary's suggestion that inconsistent treatment of this issue should continue is an unsupportable and fundamentally flawed position.

Regarding the third subissue, the recognition of overhead costs, the Provider argues that it should be permitted to allocate appropriate overhead costs to supervising physicians. It is undisputed that among the costs to be considered in developing a base year rate is the cost of supervising physicians. However, the Provider had not set up a cost center for supervising physicians during the base year.[16] Although such a cost center was later set up for these physicians, the corresponding overhead costs for the base year could not directly be allocated because the supporting documentation no longer existed on audit in 1990, six years after the base year had closed. The Intermediary has taken the position that contemporaneous documentation was required to support the allocation.[17]

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12 Tr. at 137-38.

13 Id.

14 Tr. at 169-171.

15 Tr. at 176.

16 Tr. at 143.

17 Tr. at 143-44.

The Provider proposes that since the audit took place well after the 1984 documentation had been destroyed in connection with the Provider's five year document retention policy,[18] it should be permitted to create surrogate statistics. The use of such statistics is a valid accounting practice and involves areas in which the costs would be easily calculable, such as square footage-based figures for areas, and employee number-based figures for other items.[19] The Intermediary has refused to consider such statistics even though the costs were actually incurred in the operation of the Provider and were appropriately attributable to the supervising physicians at issue.[20] In fact, the surrogate figures that could be used to allocate appropriate costs to supervising physicians already were prepared in draft form and were discussed with the Intermediary's Albany, New York office. However, the representatives of the Intermediary have consistently refused to permit the Provider to submit this documentation.[21]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that there are three issues in dispute. Regarding the critical care fellows subissue, the Intermediary argues the following. First, with respect to the regulatory requirements of 42 C.F.R. §§ 413.86(j)(1)(i) and (ii), a provider must make a request for a reclassification within 180 days of its Notice of Average Per Resident Amount and submit documentation supporting that request. If the prospective payment base year is implicated, a provider must make a request for a corresponding adjustment to that base year as well and submit relevant documentation. Thus, the Provider has to make two requests and submit two kinds of documentation. The Provider did not do any of this. There has been testimony that the prospective payment base year is implicated in this issue, so the two request/two documentation requirements would control.

Regarding the documentation the Provider did submit immediately before the hearing, the Intermediary wishes to emphasize that the Provider has changed its case from a 42 C.F.R. § 413.86(b)(1) case to a 42 C.F.R. § 413.86(b)(2) case. The Intermediary originally made an adjustment because of 42 C.F.R § 413.86(b)(1). The Provider did not have an adjustment because of that subsection. The Provider did not have a critical care subspecialty approved by ACGME as of 1984.[22] Therefore, the Provider deleted the cost and the FTEs related to critical care fellows. Now the Provider says the cost it incurred qualifies under 42 C.F.R. § 413.86(b)(2) because the time that the residents spent in this program in 1984 could qualify

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18 Tr. at 143.

19 Tr. at 145-46.

20 Tr. at 147.

21 Tr. at 186, 195.

22 See Intermediary Exhibit E.

them for specialties that were granted in later years. The Intermediary argues that the Provider has not made the necessary connection between the time spent and the certification in any subspecialty. The time spent at the Provider is not being shown in any certification process for any subspecialty in a subsequent year. There is no chain in the process. The Provider has shown that three doctors received something in subsequent years. However, there is strong doubt as to whether that "something" qualifies as a subspecialty. For Dr. Socaris, it is called "special qualifications." That is not necessarily a certification in a subspecialty. The evidence is not clear on that point. The Intermediary had not been allowed the opportunity to investigate to see whether that would be an equivalence. Is special qualification the same as subspecialty? The Intermediary does not know. It is the Provider's duty to prove that. As for Dr. Cohen, it appears from Provider Exhibit F that he was certified in internal medicine by the American Board of Internal Medicine in 1984. We do not know whether that related to the Provider's work. There is nothing indicating that he worked at the Provider during that time period, or whether his time was counted toward that certification. Again, the regulation says a provider may count toward certification of a participant in a specialty or a subspecialty listed in the current edition of two publications. The Provider has to show that there is some activity at this Provider in 1984 that counted toward that certification in a subsequent year. In the Intermediary's view, the specialty or subspecialty must have been established as of 1984. However, there is no proof for the Intermediary to follow the chain of activity at the Provider to certification under a subspecialty. The Intermediary has additional questions about whether these physicians worked at the Provider in 1984 in critical care. It also questions whether their activity was considered by anyone from the Provider to be certified in a subspecialty. Finally, the Intermediary questions whether these documents that allegedly show certification in a subspecialty are really just showing some kind of special achievement in a specialty. The document from Dr. Socaris, Provider's Supplemental Exhibit A, appears to just be a statement saying that she has some special achievements in critical care internal medicine, not necessarily rising to the level of a subspecialty.

The second subissue is the neurology FTE count. The Intermediary argues that the evidence has shown that it made no adjustment related to neurology interns; therefore, there is a jurisdictional problem. The Intermediary never added the FTE that the Provider wants to subtract. There is no Intermediary determination related to the FTE. Second, there is no documentation from the GME base year to support the Provider's contention that there were not two people working at the Provider from AMC in neurology in 1984. The Provider asks the Board to make a leap of faith that since the Intermediary discovered a problem in rate years 1986, 1987, 1988 and 1989, a problem must have occurred in 1984. That simply has not been proven. Documentation from the year in dispute is used to make adjustments. The Board should also use that. Just saying that the Provider thinks it happened in prior years is not enough. Third, the Provider is seeking to perpetrate a fraud. The Provider originally was being billed for two FTEs and was paying for two FTEs. Its clinical department knew, based on the testimony, that it was only getting one FTE. Perhaps, the Provider's finance department did not know that, but the clinical department did. Once the Provider knew of this

discrepancy, instead of coming clean with the Medicare Program, it requested the Intermediary to pay in full both for the body that it did get and the "phantom" FTE that it did not. The Provider only converted the phantom FTE to an overhead factor for purposes of this appeal. The Provider never had any computation of what was the proper overhead for the FTE that was actually at the Provider. Instead, the Provider just seeks to ask the Board and the Medicare Program to pay for that FTE it did not get, and let us just call it an overhead factor for the FTE. Finally, the fourth argument is that the Provider has not calculated how much of an FTE to remove. The Provider says it was roughly one but has not indicated exactly how much should be subtracted out of that denominator used in calculating the average per resident amount ("APRA").

Regarding the third subissue, the overhead costs applied to physician supervisory costs, the Intermediary notes that the Provider is again asking the Intermediary to do something it had not done. There is no jurisdiction. Thus, the same four arguments we stated on subissue number 2 apply. The Provider must make two requests within 180 days and submit documentation on both of those requests within 180 days for both the GME base year and the PPS year. The Provider did neither of those. Further, the Intermediary notes that the Provider is making its case relatively recently on this subissue rather than submitting the request and the documentation timely. The only thing the Provider did submit within 180 days is an appeal request to the Board. Nothing was attached to that, no documentation at all. Under the decisions of the HCFA Administrator in several cases on this point, that is not enough. The Provider has to submit a request and documentation, or a review that the request must be to the Intermediary.

The Intermediary observes that it also has a problem of documentation with respect to what the Provider wants to do now. If you get past the fact that the Provider did not submit anything within 180 days, what exactly does the Provider want to do? The Provider does not have any computations for either 1982 or 1984 in the record. The Provider is just saying, send it back to the Intermediary who will figure it all out later. Just order the Intermediary to give the Provider some indirect costs because the Intermediary would not. That is not the way an appeal works. The Provider has to document its request. If it does not do this within 180 days, then certainly by the date of the hearing. The Provider has not submitted anything at all.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A) - Reasonable Cost

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

§ 413.86	-	Direct Graduate Medical Education Payments
§ 413.86(b)	-	Definitions - Approved Medical Residency Program
§ 413.86(j)	-	Adjustment of a Hospital's Target Amount or Prospective Hospital - Specific Rate

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the controlling law, regulations, manual instructions, facts, parties' contentions, evidence submitted and post-hearing briefs finds and concludes the following for each subissue. Regarding whether this appeal concerns the base year only or the base year and rate years, i.e., the years subject to the results of the base year, the Board finds that the appeal only concerns the base year. Even though various arguments and facts relate to the base and rate years, the decision only concerns the disputes concerning the base year. However, the Board notes that the modifications or adjustments addressed below can be carried forward to subsequent rate years.

Regarding the critical care fellows subissue, the Board finds that the Provider properly included the critical care fellows in its APRA base year calculation. The Provider has clearly presented sufficient facts to establish that it had residents performing critical care activities even though no formal program had been established. The regulation at 42 C.F.R. § 413.86(b) offers four options for the recognition of an approved medical residency program. The Board finds that the Provider has met option number two which states:

> . . . .(2) May count towards certification of the participant if listed in the current edition of either of the following publications:
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> (i) The Directory of Graduate Medical Education Programs published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications, 515 North State Street, Chicago, Illinois 60610; or

(ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties, and available from American Board of Medical Specialties, One Rotary Center, Suite 805, Evanston, Illinois 60201.

42 C.F.R. § 413.86(b).

Provider Exhibit C, the American Board of Medical Specialties 1984 Annual Report and Reference Handbook specifically lists critical care medicine as an American Board of Anesthesiology Special Certification. The testimony[23] at the hearing offered sufficient credibility that residents were performing critical care in 1984, the base year. In fact, the Intermediary's testimony noted that its workpapers demonstrated that various residents were critical care fellows in 1984.[24] Further, the August 28, 1984 letter to the Provider from AMC states that the affiliation between the parties exists in critical care.[25]

Regarding the neurology FTE count subissue, the Board finds that it will address only the facts and arguments related to the base year calculations. In reviewing the base year facts and evidence, the Board finds no detailed evidence to indicate any specific audit changes to the base year. The Board observes that there were cost year and APRA base year audits performed by the Intermediary for resident costs. Both audits made no adjustments to the 2.18 FTEs included in the Provider's filed cost report. The Board finds no reason to change this decision.

Regarding the indirect cost subissue, the Board notes that appropriate overhead costs could be added to the supervisory physicians and included in the APRA base year determination. However, the Board observes that the Provider did not submit adequate documentation regarding which overhead expenses it wished to include and which allocation bases should be used. There was nothing in the record to support any additional overhead for the 1984 base year calculation. The Provider claims to have prepared documentation to support its request. However, the Board was not presented any specific evidence of a qualitative nor quantitative nature for review. Therefore, the Intermediary appropriately denied the Provider the opportunity to adjust the base year calculation.

DECISION AND ORDER:

The Board decides and orders as follows: (1) the year before the Board is only the base year, not the base year and rate years; (2) the critical care fellows are included in the APRA base

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23 Tr. at 50 and 63-65.

24 Tr. at 121-128.

25 See Intermediary Exhibit D.

year determination; (3) the 2.18 FTE neurology residents included in the base year by the Provider and reviewed by the Intermediary in both the cost and base year audits remains unchanged; and (4) no additional overhead costs can be allocated to the supervisory physicians. The Intermediary's adjustments are modified in part and affirmed in part.

Board Members Participating:

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

Date of Decision: February 27, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman