PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D89

PROVIDER -
American Oncologic Hospital
Philadelphia, PA

Provider No. 39-0196

vs.

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

DATES OF HEARING-
October 29, 1996 and
February 18, 1997

Cost Reporting Period Ended -
June 30, 1985

CASE NO. 91-2907M

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ISSUES:[1]

1. Did the Intermediary improperly exclude physician compensation costs, attributable to teaching and supervision of interns and residents in the departments of surgery, from the graduate medical education ("GME") costs used to compute the Provider's average per resident amount?

2. Did the Intermediary improperly exclude physician compensation costs, attributable to teaching and supervision of interns and residents in the department of radiation therapy, from the GME costs used to compute the Provider's average per resident amount?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

American Oncologic Hospital ("Provider") is a non-profit, cancer hospital located in Philadelphia, Pennsylvania. As a designated comprehensive cancer center, the Provider was permitted to opt out of the Medicare program's prospective payment system ("PPS") for inpatient operating and capital costs which Congress adopted in 1983. Accordingly, during the cost reporting period under appeal, fiscal year ended June 30, 1985, the Provider was reimbursed on the basis of retrospective cost reimbursement principles subject to a ceiling on the rate of increase in operating costs established by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"). Under the TEFRA methodology, Medicare reimbursement for a provider's operating costs is subject to a "target amount" limit on increases in allowable operating costs per discharge. Pursuant to the regulations implementing the TEFRA provisions, 42 C.F.R. § 413.40 et seq., the Provider's target amount was derived from its average operating cost per discharge in the TEFRA base year and updated annually by an inflation factor. The Provider's TEFRA base year was its cost reporting period ended June 30, 1983.

During its TEFRA base year, the Provider participated in approved residency training programs in surgery and radiation therapy and has continued to participate in those programs through the present. Since the costs of approved medical education programs were excluded from the TEFRA target rate of increase limits, they were reimbursed under Medicare's reasonable cost principles set forth under 42 C.F.R. § 405.421 (currently designated as 42 C.F.R. § 413.85). In April 1986, Congress established new payment policy for direct medical education costs for cost reporting periods beginning on or after July 1, 1985, pursuant to 42

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[1] Except for the issues stated, all other issues previously appealed by the Provider have been administratively resolved or withdrawn from this case. Subsequent to the hearings before the Board, the Provider withdrew its challenge to the validity of the reaudit regulations.

U.S.C. § 1395ww(h).[2] Under the new methodology, Medicare pays a hospital-specific per resident amount for GME activities which is determined based on a provider's average GME cost during the Federal fiscal year ended September 30, 1984 (GME base year).[3] The Health Care Financing Administration ("HCFA") implemented the statute by promulgating the regulations at 42 C.F.R. § 413.86 et seq., which included a provision requiring intermediaries to reaudit and verify the accuracy of GME base-year costs and to exclude any nonallowable or misclassified costs. If a hospital's GME base-year cost report was not subject to reopening after the three-year period provided under 42 C.F.R.
§ 405.1855, the intermediary could modify base-year costs on reaudit solely for the purpose of computing the per resident amount, but could not adjust the amount of program reimbursement for the GME base year.

In addition to providing for the reaudit of the GME base year for purposes of determining the average per resident amount ("APRA"), the regulation at 42 C.F.R. § 413.86(e)(1)(ii) also provided for adjustments of a provider's TEFRA target amount or hospital specific rate ("HSR") to account for misclassified GME costs in the TEFRA/PPS base year. Further, the provisions of 42 C.F.R. § 413.86(e)(1)(ii)(C) specifies that these costs may be included only if the hospital requests an adjustment of its TEFRA target amount or PPS HSR as described in 42 C.F.R.
§ 413.86(j)(2). With respect to the documentation necessary to support a hospital's GME base-year costs, HCFA would not apply new reimbursement principles during the reaudit but would make determination consistent with requirements under reasonable cost reimbursement and the general statutory and regulatory scheme of the Medicare program.

On its TEFRA base-year cost report for FYE June 30, 1983, the Provider allocated $54,057 of physician compensation costs from the department of surgery to the interns and residents cost center, which was accepted and used by the Intermediary to establish the Provider's TEFRA target amount. With respect to the department of radiation therapy, no physician compensation costs attributable to teaching and supervision of residents in that department were classified as medical education cost on the TEFRA base-year cost report. Upon review of the cost report, no change was made by the Intermediary as to the Provider's inclusion of such costs in the radiation therapy cost center. In connection with its GME base-year cost report for FYE June 30, 1985, the Provider reclassified $36,511 from the surgery cost center to the interns and residents cost center. This amount reflected the proportion of time spent teaching by five physicians who were compensated directly by the Provider. Citing the lack of supporting documentation, the Intermediary reclassified the claimed amount as operating expense with the issuance of the Notice of Program Reimbursement ("NPR") on December

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[2] Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, Pub. L. No. 99-272, as amended.

[3] The Provider's GME base year is the fiscal year ended June 30, 1985.

18, 1987.[4] While the Provider determined that $72,700 in professional fees for two other physicians in the department of surgery were related to teaching and supervision of residents in the surgery program, this amount was reported as operating expense in the GME base-year cost report. As to the residency program for radiation therapy, the Provider's as-filed cost report included all of the physician compensation costs in the radiation therapy cost center. Accordingly, the audited cost report which accompanied the Intermediary's NPR for the FYE June 30, 1985 did not include any physician compensation costs for resident teaching and supervision in the interns and residents cost center.

In 1990 and 1991, the Intermediary reaudited the Provider's GME base-year cost report pursuant to the new regulations at 42 C.F.R. § 413.86 et seq. On February 28, 1991, the Intermediary issued the Provider's Notice of Average Per Resident Amount ("NAPRA") based on total allowable GME costs of $175,998 and 3.82 full-time equivalent interns and residents for an APRA of $46,072.78.[5] Since the Intermediary made no adjustments to the Provider's base-year physician compensation costs, none of these expenses was included in the GME costs used to compute the base-year APRA. On August 23, 1991, the Provider appealed the Intermediary's APRA determination to 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 Provider estimates that the Intermediary's exclusion of physician teaching and related indirect costs understates its GME costs in the base year by approximately $250,000.[6]

The Provider was represented by Christopher L. Keough, Esquire and Barbara E. Straub, Esquire, of Powers, Pyles, Sutter and Verville, P.C.. The Intermediary's representative was Michael F. Berkey, C.P.A., Associate Counsel for the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's determination of its base-year APRA is inconsistent with the plain meaning and purpose of the GME reaudit regulations in 42 C.F.R. § 413.86(e). These regulations required the Intermediary to verify the amount of allowable GME costs to ensure that the applicable reimbursement principles were correctly applied, and that the base-year APRA amounts are accurately determined. The Intermediary clearly did not fulfill this obligation in that none of the teaching physician compensation costs incurred for the Provider's approved residency training programs was reflected in the APRA for the GME base year, which is used for determining GME payments in subsequent cost reporting

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4 Intermediary Exhibit I-5.

5 Intermediary Exhibit I-6.

6 See Provider's Position Paper at 18-19.

periods. Since the Intermediary has not consistently classified teaching physician costs as departmental operating expenses in subsequent cost reporting periods, the Medicare program is not reimbursing the Provider for any part of such compensation costs attributable to GME.

The Provider asserts that teaching physician compensation costs are clearly allowable GME costs under the regulations at 42 C.F.R. § 405.421 (1985) which govern the GME base year. During the GME base year, the evidence shows that the Provider participated in approved residency programs in surgery and radiation therapy; that appropriate teaching and supervision of the residents were required for accreditation of the programs; and that teaching physicians were compensated for instruction of residents in the programs. Contrary to the Intermediary's determination, the Provider contends that available base-year records are adequate documentation, and that the audited physician time allocation records from subsequent cost reporting periods substantiate the proportion of physicians' time devoted to GME during the GME base year.[7] Accordingly, physician compensation costs of $250,474 should be added to the GME costs used to compute the Provider's APRA.

The Provider argues that the applicable Medicare recordkeeping requirements that were in effect during the GME base year permitted providers to allocate physician compensation based on reasonable estimates of the manner in which physicians spent their time. The recordkeeping requirements in effect were set forth in 42 C.F.R. § 405.481 (1985), and did not require providers to maintain daily time logs, detailed time studies, or any other particular form of records to substantiate the proportion of physicians' time devoted to GME. Under the regulation, providers were only required to have written allocation agreements specifying the time physicians devoted to the provider (Part A services), time rendering patient services (Part B services), and time for services not reimbursable under Part A or Part B. The regulation also required providers to maintain "time records or other information used to allocate physician compensations;" and that providers were required to keep "each physician allocation, and the information on which it is based" for a period of four years. 42 C.F.R. § 405.481(f) and (g) (emphasis added). Accordingly, providers were not required to keep detailed time studies, and were granted substantial leeway in the types of records maintained for allocation of physician compensation.

The Provider argues that its physician time allocation records are adequate documentation for the amount of physician compensation attributable to GME during the GME base year. With respect to the department of radiation therapy, the Provider submitted Form HCFA-339 in the format prescribed by the manual instructions.[8] As for the department of surgery, the Provider states that it is impossible to know whether it had Form HCFA-339 during the GME base year since it was not required to retain those records for a period of more than four years. However, the Provider did submit detailed time logs showing the manner in which five

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[7] See Provider Exhibits 43-45, 51-53, 57 and 58.

[8] See Provider Exhibits 20 and 42.

physicians spent their time during the month of March, 1984.[9] These records were prepared nearly contemporaneously with the GME base year and were consistent with the recordkeeping requirements which existed at that time. In addition, the Provider submitted contemporaneous effort statements for two other physicians in the department of surgery which are also acceptable documentation for the GME base year.[10] These effort statements covered the GME base year, and the physicians certified that the statements accurately reflected the percentage of time they devoted to teaching activities. The Provider asserts that the daily logs and effort statements reflect the same information as would be reported on the Form HCFA-339. Further, while the data submitted on Form HCFA-339 is cast in the form of annual numbers of hours worked, the Provider points out that those figures are generally estimates that are extrapolated from records covering periods of two weeks or less.

Contrary to the Intermediary's contention, the Provider argues that it was not required to have detailed physician time studies for time devoted to GME under the recordkeeping regulations in effect during the GME base year. The alleged requirement for time studies is a new documentation standard which the Intermediary seeks to impose on the Provider for purposes of the NAPRA reaudit. The Provider notes that the Intermediary admitted as much in several instances. In a letter to the Provider dated April 25, 1990,[11] the Intermediary acknowledged that "the audit instructions prescribed by the Health Care Financing Administration for this review, differs somewhat from those in effect at the time of the original cost report audit." Further, the Intermediary's witness testified at the hearing that "the recordkeeping requirements changed based on the reaudit."[12] It was also the Intermediary's view that the Board should apply the new recordkeeping requirements developed for purposes of the NAPRA reaudit, as opposed to the requirements which were in effect in 1985. The Provider insists that the Intermediary is clearly wrong, and that the Board should not impose recordkeeping requirements which were not in effect during the GME base year. The application of such retroactive documentation standards violates the notice and comment rulemaking procedures prescribed by the Administrative Procedure Act, 5 U.S.C. § 553, and the Supreme Court's proscription against retroactive rules in Bowen v. Georgetown, 488 U.S. 204 (1988).

As to the Intermediary's allegations that there were other problems with the physician time allocation records, the Provider contends that such imputations are groundless and would not affect the clear reliability of the records in their totality. The minor errors in time allocation records and summaries emphasized by the Intermediary represent minute and immaterial

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9 See Provider Exhibit 50.

10 See Provider Exhibits 15 and 16.

11 Intermediary Exhibit I-32.

12 Tr. (Feb. 18, 1997), at 97-98.

variances which are baseless, pointless and/or immaterial. In the final outcome, the minor errors detected would not make a material difference in the teaching percentage allocation determined for the GME base year. As to the Intermediary's concern that there were no written contracts with the physicians in the department of surgery showing that they were only being paid for Part A services, the Provider points out that the Intermediary could not identify any legal authority that imposes such documentation requirements. Moreover, the Intermediary allowed all of the compensation paid to physicians in the department of surgery as Part A operating cost in the audited cost report for the GME base year. Although the Intermediary expressed a difficulty in reconciling the hours reported on the physician allocation agreements to the Provider's summary analysis, the Intermediary did not allege any problems with the physician time allocation records (Form HCFA-339) for the department of radiation therapy in the GME base year.

Even assuming arguendo that the available base year records are inadequate, the Provider contends that the Board must determine a reasonable amount of base-year compensation cost attributable to GME based on the Provider's records from subsequent cost reporting periods. In support of this position, the Provider cites the Paperwork Reduction Act[13] which provides that a federal agency may not impose or sponsor a recordkeeping requirement on any person unless the requirement has been approved by the Office of Management and Budget ("OMB") [44 U.S.C.
§§ 3507(a) and 3507(f)]. This act also prohibits the imposition of a penalty for failure to maintain or provide information which is required under a recordkeeping requirement that has not been approved by OMB:

> Notwithstanding any other provision of law, no person shall be subject to any penalty for failing to maintain or provide information to an agency if the information collection request involved was made after December 31, 1981, and does not display a current control number assigned by the Director, or fails to state that such a request is not subject to this chapter.

44 U.S.C. § 3512 (emphasis added)

The Provider points out that the four-year recordkeeping requirement for physician time allocation records under 42 C.F.R. § 405.481 was approved by OMB.[14] Thus, to the extent that the Provider is required to produce base-year physician time allocation records after June 30, 1989, it is being subjected to an unapproved recordkeeping requirement of greater than four years, and no penalty may be imposed for failing to comply with that extended requirement. The regulations implementing the Paperwork Reduction Act define the term "penalty" to include not only the imposition of punishment, but also the denial of a benefit [5

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13 Provider Exhibit 67.

14 See 48 Fed. Reg. 8910 (1983) - Provider Exhibit 62.

C.F.R. § 1320.3(j)].[15] In addition, the regulations provide that:

> Whenever an agency has imposed a collection of information [i.e., a recordkeeping requirement] as a means of proving or satisfying a condition for the receipt of a benefit or the avoidance of a penalty, and the collection of information does not display a currently valid OMB control number [i.e., is not approved] or inform the potential persons who are to respond to the collection of information, as prescribed in § 1320.5(b), the agency shall not treat a person's failure to comply, in and of itself, as grounds for withholding the benefit or imposing the penalty. The agency shall instead permit the respondents to prove or satisfy the legal conditions in any other reasonable manner.

5 C.F.R. § 1320.6(c) (emphasis added).

Accordingly, the Provider cannot be required to produce base-year allocation records to prove the amount of physician compensation attributable to GME in its base year. That requirement would deprive the Provider of the benefit of an accurate per resident amount due to its failure to comply with an unapproved recordkeeping requirement in excess of four years. Therefore, the Provider contends that it must be permitted to show the amount of physician compensation cost attributable to GME through other reasonable means, which would include the physician allocation records for fiscal years 1988 through 1990.

While the Intermediary objects to the use of subsequent period records, the Provider contends that its residency programs in the base year were essentially the same as those in the subsequent cost reporting periods. One factor relied upon by the Intermediary to support its position is a letter from the Provider to the Intermediary, dated February 7, 1992, which stated that the surgery program changed after the base year.[16] The Provider contends that the letter is being used out of context and in an improper manner to urge the Board not to rely on subsequent period records to support the allocation of physician compensation cost in the GME base year. Since the Intermediary had suggested the use of an allocation basis solely on the application of time studies completed by the physicians for fiscal year 1990, the Provider insists that the purpose of the letter was to argue its negotiating position that available physician time allocation records from the base year itself should not be disregarded. The only difference in the surgery program in subsequent cost reporting periods was that the number of residents had increased by approximately 1.5 full-time equivalent residents. Since the letter was written in the context of settlement negotiations between the parties, the Provider insists that its content is privileged and may not be used against the Provider to invalidate a claim asserted by it in this litigation. With respect to the radiation therapy

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[15] See Provider Exhibit 68.

[16] Intermediary Exhibit I-28.

program, the Intermediary suspects that the program might have changed from year to year because different teaching percentages are reflected on the physician time allocation records for each year. The Provider notes that it would be suspicious if the percentages did not fluctuate, and the fact that they did change from year to year reflects that the physicians kept honest records. The Provider insists that the evidence does not support the Intermediary's allegation, but rather shows that the surgery and radiation therapy programs remained essentially the same during the period from 1984 through 1990.

The Provider contends that, for purposes of Medicare reimbursement audits, documentation from prior and/or subsequent cost reporting periods is commonly used to support a claim for the period under review. Thus, the application of subsequent-year records is not unique to the NAPRA reaudits. Moreover, various Board and HCFA Administrator's decisions have accepted the use of such data to validate amounts claimed for various cost reporting periods. In Washington Hospital Center v Mutual of Omaha, PRRB Decision No. 88-D7, December 9, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,811, aff'd HCFA Administrator, February 4, 1988, Medicare and Medicaid Guide (CCH) ¶ 36,850, the Administrator approved the application of a 1987 study of a hospital's cafeteria costs to a seven-year period beginning more than eleven years earlier. Similarly, in Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Minnesota, PRRB Decision No. 95-D10, December 7, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,970, aff'd HCFA Administrator, February 2, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,136, the Administrator ruled that a provider may increase the amount of physician compensation cost that was classified as GME in the provider's original audited base year cost report where; (1) the provider has some base year documentation, (2) the accuracy of available base year documentation is generally substantiated by subsequent period documentation, and (3) the provider is not attempting to use subsequent year documentation to add physician compensation costs which were not claimed on the base-year cost report.

As an alternative argument, the Provider contends that, if the APRA cannot be increased to reflect an appropriate amount of physician compensation attributable to GME, then its APRA must be increased to reflect all of the GME cost recognized as reasonable in the audited cost report which accompanied the NPR issued for the GME base year. The Provider argues that its base-year cost report was final, binding and no longer subject to reopening when the Intermediary issued the NAPRA on February 28, 1991. Moreover, the NAPRA was issued long after the expiration of the applicable record retention period for physician time allocation records. Accordingly, the Provider requests that the Board correct its APRA to reflect a reasonable amount of physician compensation attributable to the teaching and supervision of residents in the departments of surgery and radiation therapy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its calculation of the Provider's APRA fully complied with the express provisions of the applicable regulations and other appropriate authority. In

support of its contentions, the Intermediary cites seven arguments which it believes the Board must consider in denying the Provider's request for an adjustment to the APRA determination for the GME base year.[17] The first four arguments pertain to the Provider's failure to comply with the regulatory prerequisites under 42 C.F.R. § 413.86(j)(2) for requesting a reclassification of GME costs. In part, this regulation states:

> (i) General Rule. If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduation medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate.
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> (ii) Request for review. The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

42 C.F.R. § 413.86(j)(2).

First, the Intermediary insists that the Provider did not request a reclassification of its GME base- year cost within 180 days of the NAPRA. The NAPRA was issued on February 28, 1991, which granted an APRA of $46,072.78 and advised the Provider that it must request a review of misclassified costs no later than 180 days after the date of the notice.[18] The Intermediary argues that the first request from the Provider requesting a reclassification of GME costs was submitted on November 27, 1991, approximately 90 days beyond the required due date.[19] The Intermediary's second argument is that the Provider did not submit documentation to support its GME base-year reclassification request within 180 days of the issuance of the NAPRA. The Intermediary insists that most of the data submitted by the Provider for the surgery department did not come in until April and October of 1996. As for the radiology department, the time allocation records (Form HCFA-339) were submitted no

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17 Tr. (Oct. 29, 1996), at 62-68 and Tr. (Feb. 18, 1997), at 145-154 - See Intermediary's Hearing Charts 1 and 2.

18 See Intermediary Exhibit I-6.

19 Intermediary Exhibit I-26.

earlier than January 22, 1992, approximately six months late. The Intermediary's third and forth arguments deal with the TEFRA base year for the rate-of-increase ceiling, which in this case is the FYE June 30, 1983. In accordance with the regulatory requirements of 42 C.F.R. § 413.86(j)(2), if a provider requests a reclassification of costs for GME purposes, then a timely request within 180 days is also required for a corollary adjustment of the misclassified costs for the TEFRA base year. The Intermediary argues that the Provider never made a request with respect to the TEFRA base year for reclassification of costs which would have affected the target amount. In addition to its failure to file a request within 180 days, the Provider did not submit any TEFRA base-year documentation to demonstrate that such costs were misclassified until October of 1996. The Intermediary contends that the Provider's failure to meet any one of these four requirements is sufficient to defeat the Provider's claim in the instant case.

The Intermediary's fifth argument is that the various documentation submitted by the Provider to date have not been audited and contain significant problems which are not verifiable. Based on a limited review of the documents submitted to the Board, the Intermediary states that it found sufficient errors to determine that they are not acceptable and do not warrant further analysis. As examples of the deficiencies found, the Intermediary notes that some of the data on Provider Exhibit 42 were weighted while others were not, thus resulting in a mixing of apples and oranges. With respect to Provider Exhibit 50, many of the numbers did not trace between the summaries and the detailed data. In addition, some of the data had been altered without an explanation, and many of the reports were not dated and not signed. For two of the doctors in the surgery department, their time devoted to GME efforts was based on estimates that were not supported by time studies. Where time studies were utilized, the time studies were for periods that are not comparable and cannot be verified. The lack of comparability between fiscal years is further supported by the Provider's February 7, 1992, letter to the Intermediary, wherein the Provider comments on the use of the fiscal year 1984 time studies by noting that its surgical residency program remained stable through fiscal year 1986, after which it changed significantly in terms of structure and size.[20] Further evidence as to the lack of comparability is depicted in the summary data of Provider Exhibits 41 and 49 which show the physician teaching activities fluctuating erratically for fiscal years 1985 through 1993. In summary, it is the Intermediary's conclusion that the documentation and records presented are not auditable, verifiable or usable in this case, and fail to meet the recordkeeping requirements set forth under the regulatory provisions of 42 C.F.R. § 413.20 and 413.24.

Should a sixth argument be required, the Intermediary argues that the Provider cannot use subsequent period time studies to increase the amount of GME costs claimed on its as-filed cost report for the GME base year. On its original cost report, the Provider, claimed $36,000 as physician teaching costs in the surgery department, which was removed by the Intermediary during the settlement process with the issuance of the original NPR.

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[20] See Intermediary Exhibit I-28.

Accordingly the Provider could only use subsequent time studies to reinstate that $36,000 into its GME costs. Additionally, the Intermediary argues that the lack of comparability among the fiscal years also preclude the use of time studies for verification of base-year data. The Provider's GME programs have changed over the periods involved with interns and residents coming from different places, disparity in approvals occurring, and continuous fluctuations in the amount of teaching effort by the physicians involved in the residency programs. As to the Provider's reliance on the Abbott Northwestern case,[21] the Intermediary points out that there are at least five critical differences between that decision and the instant case, which would preclude its applicability. In Abbott Northwestern, the provider had base-year data for all of its claims, whereas the Provider in the instant case has no base-year data for four of the surgeons and wants to use 1984 data as an alternative. Three additional differences between the two cases is that the provider in Abbott Northwestern: (1) made a timely request for reclassification of its GME costs; (2) made a timely submission of supporting data; and (3) made a timely request for its prospective payment base year for a corresponding adjustment. Finally, the Intermediary notes that the Administrator's decision in Abbott Northwestern stated that the physician allocation agreements (Form HCFA-339) were not sufficient support for the reclassification, and that time studies were necessary to confirm the allocation of the teaching physicians' efforts. In the instant case, the time studies furnished by the Provider are wildly divergent and do not support the physician allocation data.

The Intermediary's seventh and final argument is that, if the Provider obtains the relief requested, its GME base-year costs will be substantially out-of-line with other similarly-situated providers in the area.[22] In comparing GME costs of nonrehabilitation and nonpsychiatric facilities serviced by the Intermediary in the Philadelphia area, the Intermediary determined that the average APRA was approximately $40,601, which included costs for teaching physicians as well as interns and residents. The APRA computed for the Provider for its GME base year was $46,072.78, which includes only interns and residents costs. Since the Provider is requesting an additional $250,474 as an adjustment to its GME base-year costs, this extra amount divided 3.82 interns and residents results in an additional APRA amount of $65,569.11 for teaching physicians' costs. When added to the original APRA determination of $46,072.78, the total APRA being sought by the Provider would be $111,641.88. This represents a 150 percent increase above the Provider's current APRA, and far exceeds the average APRA for comparable hospitals. Accordingly, it is the Intermediary's conclusion that the Provider's claim is substantially out of line, and that the limitation set forth under 42 C.F.R. § 413.9(c)(2) would also apply in this case.

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[21] Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D10, December 7, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,970, aff'd HCFA Administrator, February 2, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,136 ("Abbott Northwestern").

[22] See Intermediary Exhibit I-34.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - United States Code ("U.S.C."):

5 U.S.C. Administrative Procedure Act

§ 553 et seq.	-	Rule Making

42 U.S.C. Public Health and Welfare

§ 1395x(v)(1)(A)	-	Reasonable Costs
§ 1395oo	-	Provider Riembursement Review Board
§ 1395ww(h) et seq.	-	Payments for Direct Medical Education Costs

44 U.S.C. (Paperwork Reduction Act)

§ 3507 et seq.	-	Public Information Collection Activities - Submission to Director; Approval and Delegation
§ 3512	-	Public Protection

Other Statutes:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1985, Pub. L. No. 99-272, as amended.

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

§ 405.421 (Redesignated as 413.85)	-	Cost of Educational Activities
§ 405.481 (1985)	-	Allocation of Physician Compensation Costs
§ 405.481(f)	-	Determination and Payment of Allowable Physician Compensation Costs

§ 405.481(g)	-	Recordkeeping Requirements
§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1841	-	Time, Place, Form, and Content of Request for Board Hearing
§ 405.1855	-	Evidence at Board Hearing
§ 405.1867	-	Source of Board's Authority
§ 405.1869	-	Scope of Board's Decision-Making Authority
§ 413.9	-	Cost Related to Patient Care
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.40 et seq.	-	Ceiling on Rate of Hospital Cost Increases
§ 413.86 et seq.	-	Direct Graduate Medical Education Payments
§ 413.86(e) et seq.	-	Determining Per Resident Amount for the Base Period - Appeal Rights
§ 413.86(j) et seq.	-	Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate - Misclassified Costs
§ 413.170(h)(2)	-	Payment for End-Stage Renal Disease (ESRD) Services - Other Appeals

3. Regulations - 5 C.F.R.:

§ 1320.3(j)	-	Controlling Paperwork Burdens on the Public-Penalty
§ 1320.6(c)	-	Public Protection

4. Federal Register:

48 Fed. Reg. 8910 (1983)

5. Cases:

Bowen v. Georgetown, 488 U.S. 204 (1988).

Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Dec. No. 95-D10, December 7, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,970, aff'd HCFA Administrator, February 2, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,136.

Washington Hospital Center v. Mutual of Omaha, PRRB Dec. No. 88-D7, December 9, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,811, aff'd HCFA Administrator, February 4, 1988, Medicare and Medicaid Guide (CCH) ¶ 36,850.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, documentary evidence presented,[23] testimony elicited at the hearing, and the Provider's post-hearing brief, finds and concludes that the Provider has not presented acceptable documentation to support a reclassification of physician compensation costs relating to the departments of surgery and radiation therapy to the interns and residents cost center for purpose of computing the Provider's APRA.

The Board prefaces its decision on the substantive issues in this case by addressing the universal jurisdictional concerns raised by the Intermediary with respect to appeals that involve the reclassification of GME base-year costs. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all Medicare regulations promulgated pursuant to Title XVIII of the Social Security Act, as amended. With respect to GME costs and the APRA determination,

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[23] Per agreement by the parties, the Provider withdrew Provider Exhibits 46, 47, 48, 54, 55, 56 and 59. In addition, Provider Exhibits 41, 49, 61, 62 and 71 were revised by the Provider to incorporate changes requested by the Intermediary. See Tr. (Oct. 29, 1996), at 29-39.

the controlling statutory and regulatory provisions are 42 U.S.C. § 1395ww(h) and 42 C.F.R. § 413.86 et seq. The GME statute was enacted for the purpose of establishing a new and more accurate reimbursement methodology which would effect the computation of an APRA based on all incurred GME costs recognized as reasonable. In implementing the statutory provision, HCFA promulgated regulations that set forth a reaudit process designed to offer a two way street for ensuring the accuracy of the GME base-period costs. The goal of the regulations was to properly determine accurate costs for the GME base-year calculation, which would include both increases and decreases of costs resulting in a correct base-year amount.

Once the intermediary computes a per resident amount which it believes is correct, the intermediary formalizes its final determination through the issuance of a NAPRA. Upon receipt of this notification, a provider's right to appeal the intermediary's NAPRA arises under 42 U.S.C.
§ 1395oo, and is provided for in 42 C.F.R. § 413.86(e)(1)(v). Under the provisions set forth in 42 C.F.R. § 413.86(e)(1)(v), a provider may appeal the NAPRA determination within 180 days of the date of the notice. The Board finds that the appeal process set forth under 42 C.F.R.
§ 413.86(e)(1)(v) is not limiting in its appplication, and does not change the law and regulations which govern what is appealable to the Board. In this regard, a NAPRA is no different from an intermediary's determination under an NPR, and would be subject to the same appeal process set forth in 42 C.F.R. §§ 405.1835-.1869. The regulation at 42 C.F.R. § 405.1841 establishes the general requirements for filing an appeal with the Board where a provider is dissatisfied with an intermediary's determination. With respect to additional issues which may surface during the appeal process, this regulation states that "[p]rior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof." The scope of the Board's authority is further amplified under 42 C.F.R. § 405.1869, wherein the Board is granted the power to consider other modifications covered by a cost report even though such matters were not considered in the intermediary's determination. It is the Board's position that the misclassified GME costs at issue in this appeal are fully within the purview of the Board's regulatory authority.

With respect to the review and documentation requirements set forth under 42 C.F.R. § 413.86(j) et seq., the Board does not view this regulation section as a condition precedent to the appeal rights granted under 42 C.F.R. § 413.86(e)(1)(v). If HCFA had intended such limitations for appeals emanating from the issuance of a NAPRA, it should have included such specific appeal provisions in the GME regulations similar to those set forth under 42 C.F.R. § 413.170(h)(2) for appeals relating to End-Stage Renal Disease exception requests. The Board finds that the requirement under 42 C.F.R. § 413.86(j) et seq. to submit supporting documentation within 180 days after the date of the NAPRA only applies where an intermediary would effect an adjustment to a provider's APRA. However, where a provider appeals an intermediary's APRA determination to the Board, the regulation at § 405.1855

controls the submission of supporting documentation. The regulation at 42 C.F.R. § 405.1855 states the following:

> Evidence may be received at the Board hearing even though inadmissible under the rules of evidence applicable to court procedure. The Board shall give the parties opportunity for submission and consideration of facts and arguments and during the course of the hearing should, in ruling upon admissibility of evidence, exclude irrelevant, immaterial, or unduly repetitious evidence. The Board shall render a final ruling on the admissibility of evidence.

42 C.F.R. § 405.1855.

The Board does not believe that a provider's timely appeal under the controlling provisions of 42 C.F.R. §§ 405.1835-.1841 and 42 C.F.R. 413.86(e)(1)(v) should fail based on the pretense that the evidence must be rejected under a regulatory provision that pertains to a separate and distinct review process conducted by an intermediary. Accordingly, it is the Board's conclusion that it has complete jurisdiction over the GME issues in dispute in this case, and that the documentary evidence is admissable in accordance with the regulations and rules governing the Board's hearing procedures.

As to the merits of the case, the Board finds that the documentation submitted by the Provider to support the reclassification of the physician compensation costs is not auditable or verifiable in accordance with the regulatory provisions of 42 C.F.R. § 413.20 and § 413.24. Under the general recordkeeping requirements of 42 C.F.R. § 413.20, a provider participating in the Medicare program must maintain an adequate system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors. The provisions of 42 C.F.R. § 413.24 further address a provider's responsibility for maintaining adequate financial and statistical records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purpose for which it is intended. Additionally, the regulation at 42 C.F.R.
§ 405.481(g) provides recordkeeping requirements specific to the allocation of physician compensation, and requires providers to maintain time records or other information used to allocate physician compensation in a form that permits the information to be validated by the intermediary.

In the instant case, the Board notes that the only contemporaneous records furnished by the Provider consisted of Form HCFA-339s, which reflected time allocation estimates for physicians in the radiation therapy department. However, the Board finds that the time studies which were performed in later periods for the purpose of validating the Form HCFA-339s do not support the allocation agreements for the GME base year, and cannot be used to corroborate the Provider's reclassification request. Moreover, the yearly summary of the physician teaching activity (Provider Exhibit 41) shows a teaching percentage variation from

a low of 13.55 percent for fiscal year 1989 to a high of 42.24 percent for the GME base year. Given the erratic nature of this supporting documentation, it is the Board's conclusion that the Provider's time studies for the radiation therapy department do not produce convincing and credible evidence to sustain the Provider's allocation of physician compensation to the interns and residents cost center.

Regarding the surgery department, the Board finds the absence of contemporaneous records, coupled with the lack of convincing and auditable time studies, also preclude a reclassification of physician compensation costs to the interns and residents cost center for the GME base year. The Provider's reliance on time studies from March of 1984 combined with the use of physician effort statements cannot be regarded as reliable and substantive records for the GME base year. As to
the time studies performed subsequent to the GME base period, the Board finds this data was neither convincing nor verifiable as supportable documentation. Further, the Board notes that the Provider acknowledged in its February 7, 1992 letter to the Intermediary that its surgical residency program changed significantly in terms of structure and size after fiscal year 1986 (see Intermediary Exhibit I-28).

In summary, the Board finds the Provider's base-year documentation for the surgery department, and the time studies performed in the subsequent years for both the radiation therapy and surgery departments, to be unacceptable documentation for the 1985 physician compensation costs that the Provider claimed were misclassified GME costs. The Provider failed to substantiate the accuracy of the base-year period documentation with comprehensive and supportable records that would validate the time records used to allocate the physician compensation costs. Since the Provider failed to maintain adequate and verifiable documentation, it is the Board's conclusion that no records exist to support an audit of this information as required under 42 C.F.R. § 413.20 and
§ 413.24.

DECISION AND ORDER:

1. The Intermediary properly excluded physician compensation costs attributable to teaching and supervision of interns and residents in the department of surgery from the GME costs used to compute the Provider's APRA. The Intermediary's determination is affirmed.

2. The Intermediary properly excluded physician compensation costs attributable to teaching and supervision of interns and residents in the department of radiation therapy from the GME costs used to compute the Provider's APRA. The Intermediary's determination is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (Concurring Opinion)
Martin W. Hoover, Jr. Esquire

Date of Decision: September 09,1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Concurring Opinion of Henry C. Wessman:

I write to concur with the outcome of the majority opinion of my colleagues, but arrive via a different trail. A prior PRRB constituency accepted jurisdiction over this case; I give deference to that decision. Were this a "first impression" situation, it is clear to me that I would deny jurisdiction due to failure to meet basic precepts of administrative law and contracts. These same precepts function as the basis for a concurring opinion denying the Provider relief, however, and thus the outcome of my analysis equates to that of my colleagues.

Calculation of the NAPRA, and the appeal rights stemming from that calculation are specific, and codified at 42 C.F.R. §413.86 et seq. The NAPRA process requires specific acts of both parties, intermediary and provider, with clear expectations and time lines. For the provider, the instructions for appeal of the intermediary-calculated "per resident amount" contain three imperatives: the provider 1)must request intermediary review, 2) with sufficient documentation, 3) within 180 days of notice from the intermediary. Whether the provider takes issue with the base-period average per resident amount [42 C.F.R. §413.86(e)(1)(v)], including misclassified operating or graduate medical education costs that effect rate-of-increase ceiling or prospective payment base year, and require adjustment of the hospital's target amount or hospital-specific rate, the protocol and procedure [42 C.F.R. §413.86(j)(1)(i) and (ii); 42 C.F.R.§ 413.86(j)(2)(i) and (ii)] calls for those three imperatives.

A basic tenet of administrative law requires appealing parties to "exhaust administrative (regulatory) remedies" during each step of the process. In the instant case, the Provider

missed two steps by failing to clearly 1)request review by the Intermediary 2)within 180 days of notice. As noted by the majority, the Provider also missed the third step when it failed to provide sufficient documentation, even for the PRRB, on direct appeal.

In addition, I view the Provider's participation in Medicare to be on a contractual basis, with the regulations embodied in the CFR incorporated into that contract by reference. Therefore, I was the Board member who proposed the "condition precedent" language that my colleagues specified as "not applicable" in the majority decision. I disagree. Both parties (the Federal government through their agent the intermediary, and the provider) to the health care service delivery contract known as Medicare are bound by the terms of that contract, and the "conditions precedent" for adjusting certain graduate medical education payments are that the provider 1)must request intermediary review, 2) with sufficient documentation, 3) within 180 days of notice from the intermediary. Again, in the instant case, not only did the Provider not exhaust available administrative remedy; it also did not fulfill the terms of the Medicare contract required as a condition precedent to gain relief.

Henry C. Wessman, Esquire
Board Member