PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D90

PROVIDER -Harborview Medical Center
Seattle, Washington

Provider No. 50-0064

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of
Washington and Alaska

DATE OF HEARING-
August 20, 1998

Cost Reporting Period Ended -
June 30, 1989

CASE NO. 92-0948

INDEX

ISSUES:

1. Did the Provider maintain adequate documentation to properly determine the paramedical education costs claimed for the physical therapy clinical training program and did those costs qualify as paramedical education costs reimbursable on a pass-through basis?

2. Was the Provider's inclusion of foreign medical graduates in its resident count proper?

3. Was the Provider's documentation adequate to support additional claimed costs related to the County Treasurer's costs of services performed for the Provider?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Harborview Medical Center ("Provider") is located in Seattle, Washington, and provides general medical and surgical services, as well as rehabilitation, psychiatric, burn unit, and other specialized services. Medicare has long recognized the Provider as a related party to the University of Washington Medical Center, as well as a related party to King County, Washington. The Provider has a separate Medicare provider number as well as a separate Board of Directors.

By letter dated September 17, 1991, Blue Cross of Washington and Alaska ("Intermediary") issued a Notice of Program Reimbursement (NPR) disallowing costs relating to Issues 1 and 2 above.[1] On March 2, 1992, the Provider filed a timely appeal of the NPR to the Provider Reimbursement Review Board ("Board").[2] Concurrently with the filing of the appeal, the Provider submitted to the Intermediary, on March 2, 1992, a request to reopen the June 30, 1989 Medicare cost report.[3] One of the issues raised in the reopening is reflected in Issue 3 above. That is, whether the Provider can reopen its cost report and claim additional County Treasurer costs which were not claimed on the original Medicare cost report. On August 5, 1993, the Intermediary issued a revised NPR for the June 30, 1989 Medicare cost report, which did not allow the additional claimed costs relating to the County Treasurer costs.[4] As a result, the Provider filed an appeal with the Board, from the revised NPR, on January 18,

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1 Provider Exhibit 1.

2 Provider Exhibit 2.

3 Provider Exhibit 3.

4 Provider Exhibit 7.

1994.[5] By letter dated March 22, 1994, the Board acknowledged receipt of the appeal from the revised NPR and incorporated that appeal as Part II of the instant case, PRRB Case No. 92-0948, the original appeal.[6]

The Intermediary contended that the Board did not have jurisdiction over Issue No. 3 pertaining to County Treasurer costs. However, the Board ruled that while the issue challenged by the Intermediary was not the subject of audit adjustments, the Intermediary considered the disputed issue when it reopened the Provider's cost report. Since its consideration formed the basis of the final determination, as reflected in the revised NPR, the issue was properly appealed to the Board.[7] Accordingly, the appeals meet the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The total reimbursement effect of the amounts in controversy is approximately $40,000. The Provider is represented by Mr. Robert C. Brown Jr. of Medical Reimbursement Advisors. The Intermediary is represented by Mr. Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

Issue No. 1 -- Paramedical Education Costs for the Physical Therapy (PT) Clinical Training Program

Facts

The Provider conducts the clinical training portion of baccalaureate programs in physical therapy for various educational institutions including the University of Washington ("University"), a related organization. Physical therapists employed by the Provider serve as teachers (preceptors) to the students.

The physical therapy paramedical education costs reported in the filed cost report were based on a time study from FY 1984 and FY 1985.[8] Direct salary costs related to the clinical training for the physical therapy program of $89,839 and 3,767 hours were claimed. At audit, the Intermediary determined that the time study the Provider utilized was not current and that specific preceptors' salaries and hours were not identified, preventing verification of the wage rate used. The Intermediary adjusted the costs claimed based on an average wage rate as opposed to the maximum wage rate for the Physical Therapy 3 job classification.[9] The NPR

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5 Provider Exhibit 8.

6 Provider Exhibit 9.

7 Provider Reimbursement Review Board letter dated May 21, 1997.

8 Intermediary Exhibit 1.

9 Intermediary Exhibit 2.

issued September 17, 1991 included direct salary costs related to the clinical training of $72,578 and 3,767 hours. Subsequently, as part of the reopening request, the Intermediary received from the Provider documentation claiming total paramedical education for physical therapy of $109,585 and 4,668 hours.[10] The Intermediary did not allow any of the additional claimed costs and believes that the paramedical education costs were properly finalized during its audit of the Medicare cost report.

PROVIDER'S CONTENTIONS:

The Provider contends that it prepared and submitted to the Intermediary on August 18, 1992, detailed work schedules for a fully documented listing of the preceptors by name, salary, students instructed in the clinical training program, and time spent by the preceptors instructing students.[11] Because the ratio of preceptor to student is one to one, only the time a preceptor was with a student was claimed on the documented listing. After examining each preceptor's work schedule, the Provider was able to segregate the time spent by preceptors in clinical educational activity. Time spent outside of the clinical education program by a preceptor treating patients was not relevant and was automatically excluded from the time reported. The time spent in clinical education was then multiplied by each preceptor's hourly rate to determine the exact cost of the time spent by the preceptor in educating the PT trainee.

The Provider contends that the Intermediary reviewed the submitted documentation and then, for the first time, raised a new criteria based on requiring the Provider to distinguish between when the preceptor is with the PT trainee conducting clinical education activities, and when the preceptor is with the PT trainee providing patient care. In place of its original criteria, the Intermediary argued that most of the time spent by the preceptors with the PT students was patient care-related, and could not be included as an allowable paramedical education cost. According to the Intermediary, the Provider must document the "incremental" additional time spent by the preceptor with the patient because of the presence of the PT trainee; then the Intermediary states that only the cost of this incremental time qualifies as allowable paramedical clinical education cost.

The Provider contends the Intermediary's "incremental" time study requirement is arbitrary and not supported by the regulations or the manual provisions. Moreover, as the letter from the Provider's Manager of Physical Therapy demonstrates, those physical therapists who serve as instructors spend 100% of their time in activities related to the trainee, providing "instruction, teaching and clinical supervision" on a one-to-one basis.[12] It is impossible for

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[10] Intermediary Exhibit 4.

[11] Provider Exhibit 13.

[12] Provider Exhibit 20.

the Provider to document the increment of additional time spent with a patient by an instructor due to his or her educational responsibilities, as the educational time relates to much more than just patient care. Each student is different and the time it takes for the student to take over all direct patient care varies. However, the additional time spent by the instructor in supervisory responsibilities remains constant or even increases. Even when the instructor's direct involvement with the patient decreases, as the student becomes more autonomous, the instructor will prepare for the next patient or complete evaluations of the student's performance. The Provider asserts that the Intermediary's attempt to limit reimbursement to the incremental increase in time with the patient would result in the Medicare program not paying its fair share of paramedical education costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the method used by the Provider to determine the educational time, which is the basis for the cost claimed, is improper. The instructors do not keep track of their time spent teaching or supervising their students. Instead, the time students are at the Provider is accumulated. The Intermediary questions the Provider's assumption that the physical therapists spend 100% of their time teaching and supervising on the days they are assigned a student. The Intermediary's position is that the physical therapists should be tracking the actual time spent teaching in order to properly allocate salary costs between patient care and teaching costs. The Provider's position is that tracking educational time versus time spent delivering patient care is unnecessary, since the educational time and the time students are at the facility are equivalent.

The Intermediary cites the following in support of its position:

> 42 C.F.R. § 413.85(g) defines costs related to educational activities, stating: "[a] provider's total costs include trainee stipends, compensation of teachers, and other direct and indirect costs of the activities as determined under the Medicare cost-finding principles in Section 413.24." Id.
>
> HCFA Pub. 15-1, Section 402.2 further specifies that: "[t]he net cost of approved educational activities cannot include any cost of usual patient care as explained in Section 502.2." Id.
>
> 42 C.F.R. § 413.24 requires that providers receiving payment on the basis of reimbursable cost must provide adequate documentation to substantiate costs claimed. 42 C.F.R. § 413.24(c) states: "[a]dequate cost information must be obtained from the Provider's 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 purposes for which it is intended." Id.

The Intermediary's position is that the data collected by the Provider does not distinguish between the types of activities performed by the physical therapists/preceptors. The Provider's assumption results in a situation where reimbursement is sought for both direct costs of the educational activity as well as patient care costs.

The Intermediary contends that it is improper to categorize 100% of a physical therapist's time as educational in the presence of an observing student if the physical therapist is performing the same duties which would qualify as 100% patient care duties, if the student were not observing. Recent Intermediary audit findings show that a student is assigned separate tasks that frees the preceptor to perform separate patient care duties.[13]

While the student may remain in the Physical Therapy Department and may be supervised, the preceptor is not teaching, but is delivering patient care. The Intermediary recognizes that the preceptors who are teaching the students have the dual role of providing patient care and teaching their students. It is agreed that if the preceptor is supervising the patient care provided by the student, the related salary falls within the definition of direct educational costs (compensation of teachers). However, in those case where the preceptor is providing all or part of the treatment, the Intermediary's position is that some of the related cost would fall into the category of usual patient care costs that would be incurred in the absence of the educational activity.

For these reasons, the Intermediary contends that its initial disallowance of paramedical education costs was in accordance with 42 C.F.R. § 413.24.

The Intermediary also contends that the additional physical therapy training costs sought by the Provider should not be recognized. 42 C.F.R. § 413.85(d)(6) excludes from educational costs: "[c]linical training of students not enrolled in an approved education program operated by the provider." Id. The following additional factors support the Intermediary's contention that the physical therapy education program is operated by the University not the Provider and that it does not qualify as a joint educational program:

a. The operator of the program, per the accreditation letter from the American Physical Therapy Association, is the University.[14] 42 CFR § 413.85(e) only recognizes costs of educational programs being conducted by provider institutions. Title XVIII of the Social Security Act, Section 1861(u), does not include related organizations in its definition of the term "provider".[15]

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13 Intermediary Exhibit 12.

14 Intermediary Exhibit 18.

15 Intermediary Exhibit 19.

b. The Provider is responsible only for the clinical training portion of the program. Per review of the courses required for graduation in the University's physical therapy program, only 2 out of the 24 required classes appear to involve clinical practice.[16]

c. The responsibility for the curriculum and the administration of the program rests with the University. The Provider does not provide or control the classroom instruction.

d. The students enroll in and receive a degree from the University. All tuition goes to the University and no portion of it is offset against the Provider's claimed costs.

e. No payments are made by the Provider to the University to assist in covering the cost of the degree program. The Provider's financial support to the Program consists of providing the facilities and the instruction for the clinical training.

f. The net financial cost to the Provider appears to be minimal and the presence of the educational program does not appear to result in significant additional costs for the Provider. The documentation submitted by the Provider for years has made the statement:

"The student programs we offer do not take away from the labor intensity or revenue producing performance of our FTEs."[17]

As no additional staff would need to be hired if this is true, any patient care the physical therapists do not perform when acting as preceptors is apparently performed by the students at no direct cost to the Provider.

g. The day-to-day operation of the program is under the control of the University. In fact the day-to-day operation of the Provider itself is under the control of the University per a letter from the State's Attorney General. It states in response to a question on the management contract the Provider is party to:

"Yes. The management contract between the two gives the University of Washington (the University) complete control over the day-to-day operations of the Hospital (the Provider)."[18]

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16 Intermediary Exhibit 11.

17 Intermediary Exhibit 14.

18 Intermediary Exhibit 22.

h. The Provider is "operated" by the University as a teaching resource for the University per a letter[19] from the State's Attorney General, that states:

> "The legislature in 1969 appropriated almost five million dollars to the University for the express purpose of operating Harborview as a teaching resource for the University..." and "Further, though theoretically the parties may decide after 10 years not to renew the contract, the state funds channeled to Harborview (the Provider) through the University will probably induce Harborview to extend the contract indefinitely." Id.

The footnotes to the FY89 financial statements discuss the management contract which exists between the Provider and the University stating:

> "The management contract recognizes the . . . . University of Washington's desire that the Medical Center (the Provider) be maintained as a continuing resource for education, training and research." and
>
> "The State Legislature has appropriated funds to the University of Washington (the University) on a biennial basis for the continuing operations of the Medical Center (the Provider) as a resource for teaching and research."[20]

These factors strongly indicate the paramedical education training program is operated by the University. The extent of the community's and the University's support and financial commitment to maintain and operate the Provider as a teaching resource suggest that the role of the Provider is just that- a teaching resource, as opposed to a partner in a joint educational program.

The Intermediary therefore, contends it would be improper to reclassify the additional costs identified by the Provider into the paramedical education cost center. The Intermediary maintains the additional paramedical education costs the Provider seeks to claim should remain as operating costs under 42 C.F.R. § 413.85(d)(6).

Issue No. 2 -- Inclusion of Foreign Dental Grad in the FTE Resident Count

Facts

The Provider participates in two dental residency training programs sponsored by the University of Washington School of Dentistry (a general practice program and an oral

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19 Intermediary Exhibit 22.

20 Intermediary Exhibit 23.

maxillofacial surgery program). Participants in the two programs serve as residents at the Provider. During FYE 6-30-89, one of the residents was a foreign medical graduate (FMG) and the Provider included that resident (to the extent of .26 FTE) in its graduate medical education (GME) resident count. The Intermediary audit adjustment 3 adjusted the number of FTE residents used in determining the payment for graduate medical education costs.[21] Excluded by that adjustment was .26 of a FTE related to the resident (who was a graduate of a foreign dental school), but who had not passed the Foreign Medical Graduate Examination in the Medical Sciences ("FMGEMS").

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly disallowed the inclusion of the resident on the grounds that he had not taken the FMGEMS. A foreign dental graduate is not required to take the FMGEMS as a prerequisite to admission to a dental residency program since that test is administered to foreign medical graduates who wish to enroll in medical residency programs. Instead, as discussed below, foreign dental graduates are required to satisfy specific dental education and state licensure requirements in order to enroll in dental residency programs. The Provider contends its dental resident satisfied these requirements and therefore should be included in the resident count.

The Provider contends the Intermediary's position is based upon a literal, but erroneous, interpretation of the GME statutory provisions. The word "medical" is used in an extremely broad, inexact sense in the statute. Accordingly, in interpreting and applying the GME provisions, HCFA has recognized that although terms such as "graduate medical education" and "approved medical residency training. program" are used in the statute, GME reimbursement encompasses dental, osteopathic, and pediatric residency programs as well. HCFA has stated: "we are interpreting the statutory use of the term "medical" in Section 9202 of Public Law 99-272 [42 U.S.C. S 1395ww(h)] to include osteopathic, dental, and pediatric residents." 54 Federal Register 40293 (September 29, 1989). See also 53 Federal Register 36596-36597 (September 21, 1988). Thus, HCFA has acknowledged that dental, osteopathic, and pediatric residents, not just medical residents, are to be included in a hospital's FTE resident count.

The Provider contends the inexact use of the term "medical" in the statute must be taken into account when interpreting the provisions relating to "foreign-medical graduates." The term "foreign medical graduate" is defined in the statute as a resident who is not a graduate of an American-accredited school of medicine, dentistry, osteopathy or podiatry. 42 U.S.C. § 1395ww(h)(5)(D). The statute permits a foreign medical graduate to be included in a hospital's resident count if "the individual has passed the FMGEMS examination." 42 U.S.C. § 1395ww(h) (4)(D). The FMGEMS was developed and administered by the Education

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[21] Intermediary Exhibit 25.

Commission for Foreign Medical Graduates ("ECFMG"). Foreign medical graduates (not foreign dental graduates) were required to pass the test in order to obtain certification from the ECFMG to enter medical (not dental) residency programs in the United States.

The Provider further contends that because foreign dental graduates cannot take the FMGEMS[22] they cannot satisfy the statutory requirement that "foreign medical graduates" pass such an examination. However, as noted above, Congress, in defining the term "foreign medical graduate," clearly recognized that foreign dental graduates may participate in residency programs. Thus, there appears to be a contradiction in the statute: Congress on the one hand acknowledged that foreign dental graduates may participate in residency programs, but on the other hand apparently created an absolute bar to their inclusion in the FTE resident count (the FMGEMS examination requirement).

The Provider contends that this contradiction should be resolved by interpreting and applying the statute in a manner which is reasonable and which implements Congress' underlying intention to include dental residents within the scope of GME reimbursement. Although foreign dental residents are not required to pass a standardized test that is the equivalent of the FMGEMS in order to enroll in dental residency programs in the United States, they are required to meet certain educational and state licensure requirements.[23]

These educational and licensure requirements perform the same function as the FMGEMS examination requirement: they provide objective criteria that must be satisfied by a foreign graduate in order to participate in a residency program.

The Provider contends these requirements should be used as a surrogate for the FMGEMS requirement in order to effect Congress' intent to include "foreign medical graduates" (which include foreign dental graduates) in the FTE resident count. In the instant case, the resident serving at the Provider met the educational requirements of the University of Washington School of Dentistry and was granted limited licensure. Accordingly, the Provider asserts the dental resident should be included in the Provider's FTE resident count for FYE 6/30/89.

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[22] The ECFMG changed its certification process in 1993. The FMGEMS was replaced with the United States Medical Licensing Examination ("USMLE"). The 1994 Bulletin of Information for the USMLE indicates the USMLE may be taken by a medical student officially enrolled in or a graduate of a foreign medical school. Thus, as was the case with the FMGEMS, the USMLE is not a dental examination and may not be taken by foreign dental graduates.

[23] Provider Exhibit 22.

INTERMEDIARY'S CONTENTIONS:

The Intermediary recognizes that graduates of foreign dental schools are considered foreign medical graduates who must meet the requirements of 42 C.F.R. § 413.86(h) to be included in the FTE resident count. However, in the case at hand, the Intermediary maintains that the regulations clearly exclude such residents from the FTE count. 42 C.F.R. § 413.86(b) includes graduates of foreign dental schools in its definition of FMGs stating:

> [F]oreign medical graduate means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations . . .
>
> (3) The Commission on Dental Accreditation and,
>
> [r]esident means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.[24]

However, 42 C.F.R. § 413.86(h) requires that such residents have passed the FMGEMS to be included in the FTE resident count, stating:

> [D]etermination of weighting factors for foreign medical graduates. (1) The weighting factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate...
>
> (i) Has passed FMGEMS

Id.

The regulations clearly and unambiguously exclude FMGs who have not passed FMGEMS from the FTE resident count. Foreign dental graduates are clearly defined as FMGs.

The Intermediary contends that the regulations could have limited the application of the FMGEMS requirement by distinguishing which residency program it applies to, if it did not apply to all of them. Since they did not, the Intermediary is limited to the application of 42 C.F.R.
§ 413.86(g) to dental FMGs. To determine whether the requirements of the regulations are valid or contradict Congressional intent is not within the authority of the Intermediary. As the

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[24] Intermediary Exhibit 26.

Supreme Court states in Bethesda Hospital Ass'n. v. Bowen, 485 U.S. 399 (1988), "providers know that, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile." Id. The Intermediary contends that the Provider, in this case, is contesting the validity of the regulation, not the Intermediary's application of the regulation.

Issue No. 3 -- County Treasurer Costs:

Facts

The Provider claimed, in its filed cost report, costs for services performed by the King County's Office of Financial Management (County Treasurer), a related organization. The Intermediary finalized the cost report without adjusting the $12,389 claimed as County Treasurer costs. This amount was based on the number of warrants issued times the cost of issuance of a warrant as documented by the County Treasurer. In 1992, the Provider appealed this issue and concurrently requested it as a reopening issue. In the documentation submitted 9/3/92, the Provider claimed additional costs of $173,335 on the basis that the County Treasurer performs more services on behalf of the Provider than just processing warrants. The amount requested was determined by taking total County Treasurer expenses times the warrant ratio.[25] The Intermediary requested documentation identifying the additional services performed and an acceptable basis on which to allocate the additional claimed costs. Based on the inadequacy of the documentation, the Intermediary did not allow the additional claimed costs. The Provider also added this issue to the appeal from the revised NPR dated August 5, 1993. To obtain support for its position, the Provider filed with the Intermediary a discovery request dated December 23, 1993.[26] The Provider's discovery request asked the Intermediary to produce Intermediary work papers relating to the allocation of county costs in order to demonstrate that the Intermediary was treating the Provider differently than other county-related hospitals. Initially, the Intermediary objected to the request stating that the information requested was not relied upon by the Intermediary in making any of its adjustments, and the additional costs being claimed in the appeal were not claimed on the as-filed or as-finalized cost report. The Provider filed a Motion To Compel Discovery with the Board on July 7, 1994. On September 30, 1994, the Board granted the Provider's request, citing that the request for information was material and relevant to the issue under appeal.

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[25] Intermediary Exhibit 29.

[26] Provider Exhibit 24.

PROVIDER'S CONTENTIONS:

The Provider contends that it is well established that it is a related party to King County, Washington, and that certain governmental support services are includable in the Provider's allowable costs. County Treasurer costs have been historically allocated by the Intermediary to county-related hospitals on the basis of County warrants issued. That is, the number of warrants issued for a provider by a related County Treasurer's office was expressed as a percentage of total County treasury warrants. This percentage was then multiplied by total County Treasurer costs to determine a provider's allocation of these related party costs. With respect to the cost report for FYE 6/30/89, the Provider contends it significantly understated its allocation by only claiming those County Treasurer costs incurred in producing the warrants themselves. Using the warrant percentage as the allocation statistic, the Provider contends its share of County Treasurer costs should have been $185,725.[27]

The Provider contends that it adequately documented the additional claimed costs and that the warrant processing percentage should be used as the basis for allocation. The Provider pointed out that the warrant percentage method had been approved for use by the Intermediary with respect to all County-related providers in Washington since 1981. Accordingly, the Provider asserts the Intermediary is treating the Provider in a manner different from all other County-related hospitals.

The Provider continues to assert that the Intermediary has never fully complied with the discovery request. As a result, the Provider contends it has not been able to establish its substantive argument on this issue; which is that it has not been treated the same as similar hospitals. Alternatively, the Provider argues that the Intermediary's failure to comply merits deeming the facts asserted by the Provider to be true.

INTERMEDIARY'S POSITION:

The Intermediary contends the Provider has yet to document that the amounts claimed are allowable in accordance with the provisions of HCFA Pub.15-1, Section 2156. This section addresses the costs of governmental support services stating:

> The costs of such facilities and services are includable in the allowable costs of the provider to the extent they are (1) reasonable, (2) related to patient care, (3) allowable under Medicare regulations, and (4) allocated on an acceptable basis.

Id.

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[27] Intermediary Exhibit 38.

The Intermediary contends that in order to determine whether the costs are reasonable, allowable under Medicare, and related to patient care, the County Treasurer must identify the services performed for the Provider and the related costs. To date, this has not been adequately done. When asked to document what services are performed for the Provider by the County Treasurer, a summary of the functions of the various departments in the County Treasurer's office was produced.[28] The Intermediary contends that not all of the functions in the summary apply to the Provider.

The Intermediary also contends that the warrants ratio (warrants issued for the Provider divided by the total warrants issued) is an unacceptable basis to apply to the costs of the additional services the Provider is seeking to claim. In a letter to the Provider dated 12/9/93, the Intermediary stated in part:

> "[C]ertainly the application of this ratio to the allowable costs related to the performance of processing warrants would result in an allowable cost of processing warrants to be included on the Medicare cost report. However, there are more services than just warrants processing being provided... That was the rationale used to support inclusion of all the Treasurer's costs. If the Provider wants to include the costs related to all additional services, appropriate allocation bases should be developed as well. The FI contends that the warrants ratio is an inappropriate basis to apply to the costs related to other services."[29]

The Intermediary asserts that the Provider's other primary contention (the Intermediary did not comply with the discovery request) is without merit. The Intermediary reviewed all documents for all district hospitals claiming County Treasurer costs. In each instance (audit or desk review) where an Intermediary generated a work paper, it was submitted in response to the Board Order. There are no Intermediary generated work papers for the other 23 district hospitals. Thus, the Intermediary contends it fully complied with the Board's Order regarding the discovery request.[30]

Finally, the Intermediary contends that regardless of the additional costs being sought, the amount allowed other providers is not relevant. The costs claimed must be documented, especially when they are materially different from the costs as filed. While such a request may be burdensome, it is appropriate, necessary and reasonable per 42 C.F.R. § 413.24. Absent the required documentation, the Intermediary recommends exclusion of the additional

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28 Intermediary Exhibit 33.

29 Intermediary Exhibit 35.

30 See Blue Cross and Blue Shield letter dated February 15, 1995.

costs from the Provider's cost report.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

§ 1861(u)	-	Provider of Services

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

§ 1395ww(h) et seq.	-	Payments for Direct Graduate Medical Educational Costs

3. Other Statutes:

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") of 1986, Pub. L. No. 99-272, 100 Stat. 82.

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.85 et seq.	-	Cost of Educational Activities
§ 413.85(d)	-	Activities Not Within the Scope of This Principle
§ 413.85(e)	-	Approved Programs
§ 413.85(g)	-	Calculating Net Cost
§ 413.86 et seq.	-	Direct Graduate Medical Education Payments
§ 413.86(b)	-	Definitions
§ 413.86(g)	-	Determining the Weighted Number of FTE Residents

§ 413.86(h)	-	Determination of Weighting Factors for Foreign Medical Graduates

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

§ 402.2	-	Cost of Educational Activities Definition Net Cost
§ 502.2	-	Usual Patient Care
§ 2156	-	Allowable Costs of Governmental Support Services to State and Local Governmental Providers

6. Federal Register:

53 Fed. Reg. 36596-36597 (September 21, 1998).

54 Fed. Reg. 40293 (September 29, 1989).

7. Cases:

Bethesda Hospital Assn. v. Bowen, 485 U.S. 399 (1988).

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:

Issue 1 -- Paramedical Education Costs for the Physical Therapy (PT) Clinical Training Program

The Board finds and agrees that the Provider adequately developed an appropriate time study to document the additional claimed costs. Specifically, Provider Exhibit P-13 contained a listing of instructors, their salaries and work schedule, and the names of the students participating in the clinical training program. The Board noted that time spent outside of the clinical education program was excluded from the time report. In addition, the Provider did not bill the Medicare program for any of the instructors's PT time spent supervising the trainees. Thus, only the time spent in educational activities was multiplied by each instructor' hourly rate to determine the claimed educational costs for PT clinical training.

The Board finds that the regulations at 42 C.F.R. § 413.85(g) and 42 C.F.R. § 413.24 do not support the Intermediary's contention that the Provider must distinguish between the time the instructor is with the PT trainee conducting clinical education activities and when the instructor is with the PT trainee providing patient care. Therefore, the Intermediary request that the Provider document the instructor's incremental time with a patient, due to the presence of the trainee, is without merit. The Board points out the analogy to those situations wherein a physician resident's time spent with an instructor is viewed as valid teaching time. Accordingly, the Board finds that the time study, as developed by the Provider, represents the best evidence in the record.

The Board notes that the Intermediary has raised the issue that the Provider is not the true operator of the PT clinical training program. As such, the additional claimed costs would only be allowable as general operating costs rather than on a pass through basis, as sought by the Provider. The Board finds that the Provider, the University of Washington Medical Center, and King County, Washington are all related parties. This had been established in prior Medicare audits. The record indicates that the PT training program takes place on the Provider's premises, and that the Provider has documented that it incurred the claimed costs. While many of the administrative aspects of the PT training program reside with the University of Washington, the evidence indicates the day to day operation of the clinical program takes place at the Provider.
Thus, the Board finds that the Provider is the operator of the clinical training program.

Issue No. 2 -- Inclusion of Foreign Dental Graduate in the FTE Resident Count

The Board finds that it is bound by the regulation at 42 C.F.R. § 413.86(h), which states in part that a foreign medical graduate (including a dental graduate as per 42 C.F.R. § 413.86(b)) who has not passed the FMGEMS can not be included in the FTE resident count. The literal reading and interpretation of that regulation provides no basis for a different finding. Although the Provider advances a theory of Congressional intent, which would allow for the inclusion of a foreign dental grad who has not passed the FMGEMS, no evidence of that nature was noted in the record.

Issue No. 3 -- County Treasurer Costs

The Board notes that the Provider claimed additional County Treasurer costs on a reopening basis. However, the Provider has not specifically identified those particular services that were performed by the county. HCFA Pub. 15-1, Section 2156 addresses the costs of government support services. It states: "[t]he cost of such facilities and services are includable in the allowable costs of the provider to the extent they are: (1) reasonable, (2) related to patient care, (3) allowable under Medicare regulations, and (4) allocated on an acceptable basis." Id.

The Board finds that the Intermediary was correct in requiring adequate cost data and an acceptable allocation basis to support the claimed County Treasurer costs. The Medicare regulations at 42 C.F.R. § 413.24 require that the cost data must be accurate, in sufficient detail to accomplish the purpose for which it was intended, and capable of being audited. The Board finds no evidence in the record that the Provider's records met the requirements of either 42 C.F.R. § 413.24 or HCFA Pub. 15-1, Section 2156. In summary, the Provider has not submitted sufficient documentation to support the additional County Treasurer costs claimed via its reopening request.

DECISION AND ORDER:

Issue 1 -- Paramedical Education Costs for the Physical Therapy (PT) Clinical Training Program

The Board finds that the Provider sufficiently documented the additional paramedical education costs. Additionally, the Board considers the Provider to be the true operator of the PT clinical education program. The Intermediary's adjustment reclassifying physical therapy costs is reversed and the Intermediary is directed to allow the Provider's revised submission reflecting paramedical education costs for physical therapy of $109,585 and 4,668 hours, on a pass through basis.

Issue 2 -- Inclusion of Foreign Dental Graduate in the FTE Resident Count

The Intermediary's adjustment to the GME resident count was proper. The Intermediary's adjustment is affirmed.

Issue 3 -- County Treasurer Costs

The Intermediary is correct to request adequate documentation to support additional claimed costs which differ materially from those claimed in the original cost report filing. The Intermediary's decision not to allow the additional claimed costs based on inadequate documentation is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Esquire
Charles R. Barker

Date of Decision: September 09, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman