PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D21

PROVIDER -
Boston City Hospital
Boston, Massachusetts

Provider No. 22-0104

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association
Blue Cross and Blue Shield of
Massachusetts

DATE OF HEARING-
October 22, 1998

Cost Reporting Period Ended -
September 30, 1984

CASE NO. 91-2474M

INDEX

ISSUES:

1. Was the Intermediary's reclassification of compensation for payroll physicians proper?

2. Was the Intermediary's reclassification of teaching compensation for contract physicians proper?

3. Was the Intermediary's disallowance of teaching time spent by contract physicians proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Boston City Hospital ("Provider") is a non profit institution that is located in Boston, Massachusetts. It consists of two major teaching hospitals that currently train over six hundred physicians in various medical specialties and sub-specialties. During its 1984 cost year, the Provider trained over two hundred physicians. A Notice of Average Per Resident Amount ("NAPRA") was issued on February 19, 1991 by Blue Cross and Blue Shield of Massachusetts ("Intermediary") following the reopening of the Provider's cost report for the fiscal year ended September 30, 1984, and has a reimbursement effect beginning with the cost reporting periods beginning on or after July 1, 1985.

The Provider disagreed with the Intermediary's adjustments and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.§§ 405.1835-.1841 and has met the Jurisdictional requirements of those regulations. The Medicare reimbursement affect is approximately $4,745,504.

The Provider was represented by Karen Wildau, Esq. of Powell, Goldstein, Frazer & Murphy. The Intermediary was represented by Bernard M. Talbert Esq. of the Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The following Provider contentions apply to all three issues.

The Provider contends that the Intermediary improperly reclassified $711,776 in compensation for payroll physicians to the Routine Adults and Pediatrics cost center. The Provider points out that under Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. 99-272, 100 Stat. 171, et seq. Congress established a new methodology for calculating Direct Graduate Medical Education ("GME") reimbursements for all periods beginning on or after July 1, 1985. In the past GME cost had been reimbursed on a reasonable cost basis. Under COBRA, however, to determine a

hospital's GME reimbursement for 1985 and for future years, the Secretary of Health and Human Services was directed to calculate an average amount recognized as a reasonable GME amount for each full time equivalent ("FTE") resident. A hospital's base year cost report would be reopened to make the calculation. If the base year began prior to July 1, 1985, then the calculated average amount would not have any reimbursement effect for the base year. The calculated average amount would however, be the basis of subsequent years' GME costs. That amount, adjusted for inflation for subsequent cost years that began on or after July 1, 1985, would be multiplied by the number of FTE residents and interns who are training in the hospital during the year in question.

The Provider further points out that more than three years following the passage of COBRA, HCFA promulgated implementing regulations at 42 C.F.R.§ 413.86, 54 Fed Reg. 40,286 (Sept, 29,1989). Under this directive, fiscal intermediaries reopened base year cost reports and computed GME costs using the new methodology. GME base year cost reports that were not subject to reopening under 42 C.F.R.§ 405.1885, were not subject to any overpayment recoupment procedures, as per the regulation at 42 C.F.R.§ 413.86(e)(1)(iii).

The Provider argues that the Intermediary's NAPRA issued on February 19, 1991 is incorrect. The Intermediary computed total GME costs of $8,565,790 and a total of 193 ftes, or $44,382.33 average per resident amount.[1] The Provider contends that the Intermediary's computation excluded $4,745,504, or virtually all of the teaching physician compensation cost from the average per resident amount. The Intermediary reclassified the payroll and contract teaching physicians services as operating costs and added them to the Routine Adults and Pediatrics cost center by disallowing that portion of the physicians costs that were considered to be teaching, and determined to be unsupported by adequate documentation (lack of time studies).

The Provider contends that there were two categories of teaching physician salary costs that were included in its interns and residents cost center when it filed its 1984 cost report. They were $4,033,728 for contract physicians and $711,776 for payroll physicians. The Provider considers all of these costs to be attributable to direct GME costs and supported them with time records signed by the physician or department head.

The Provider points out that the Intermediary made adjustments based on Hospital Based Physician's Time Allocation forms (maintained by the Provider) that allocated hours to the following Part A categories: teaching, research, administration, supervision, hospital services, services of general benefit and patient services not meeting Part B criteria. The Intermediary construed only those hours designated under "teaching" as GME costs. Nevertheless, even those costs that the Intermediary recognized as attributable to "teaching" services were disallowed.

---

[1]EXHIBIT P-1

The Provider argues that it historically included its teaching salary costs in the Interns and Residents cost center. Included in that cost center were only those teaching physician salaries attributable to Provider component services (Part A costs), and no amounts attributable to patient services (Part B). The Provider contends that it supported its 1984 allocation of teaching physician salaries to the Interns and Resident cost center, using the Hospital Based Physician's Time Allocation forms, a format that is consistent with Medicare regulations requiring an allocation between Part A, Part B, and non-A or B activities. That format had been used by the Provider in prior years, and had been accepted in the past by the Intermediary. It is both inequitable and improper for the Intermediary to demand retroactively a more detailed format. The Provider points out that its position is supported by Good Samaritan Hosp. v Cross and Blue Shield Assn., PRRB Dec. No. 93-D79 Aug. 26,1993 Medicare and Medicaid Guide (CCH) ¶ 41,693. (Reversal of Intermediary's adjustment ultimately upheld in Good Samaritan Hosp. v. Shalala 873 Supp. 1083 (S.D. Ohio 1994)). ("Good Samaritan").

The Provider argues that the Intermediary reclassified physicians compensation costs to routine operating costs because the Provider failed to properly break down teaching physicians activities. The Provider contends that teaching costs include physician compensation for teaching, supervision, and administration, while the Intermediary accepted only those costs that were expressly designated teaching. The Intermediary was unable to point to any regulation or other requirement that teaching costs do not include supervision and administration.

The Provider argues that the Intermediary's contention that the physician allocation or supporting documentation for the 1984 Cost reporting period were inadequate or unfounded is without foundation. The Intermediary was required under HCFA instructions to advise the Provider that it may use subsequent period data in the form of a time study.[2] The Provider points out that the Intermediary would not permit a time study to support all claimed teacher's salary costs, including administration and supervision, all costs that were reclassified as operating costs, as well as those that were recognized as teaching. These costs were rejected for insufficient supporting documentation. This was contrary to HCFA instructions.[3]

The Provider contends that the general mission of the Provider in the community is that of a teaching institution, including the offering of graduate medical education programs. The graduate programs cannot operate without the teaching services of qualified physicians. Under 42 C.F.R.§ 413.85(g), teachers' compensation is an allowable direct GME cost. Therefore, it was appropriate for the Provider to include compensation of its teachers in the Intern and Resident cost center. The Provider points out that in Barnes Hospital v. Mutual of

---

[2]Exhibit P-8

[3]Exhibit P-5

Omaha PRRB Dec. No. 94-D38, May 31, 1994 Medicare and Medicaid Guide (CCH) ¶42,420 ("Barnes") the Board stated:

> The provider's per resident amount will not include any amount for teaching services or for any of the administrative functions... such as recruiting and scheduling of residents. It is implausible that a major teaching institution ... which operates numerous highly competitive and well-respected residency programs that are known nationally for the quality of their faculty, should not have any costs for teaching services.

Id.

The Provider argues that as in the Barnes case, it is a major Boston teaching hospital and it incurred significant teaching costs in the form of physicians salaries. The Teachers' compensation costs should have been included in the per resident calculation. Because they were not, the Medicare share of these compensation costs likely will be borne by the Provider's non-Medicare patients, a result expressly prohibited by the Medicare statute.

Issue -1- Payroll Physicians:

The Provider contends that it included in its base year cost report those compensation costs it believed contributed to the quality of patient care, relying on what it had historically included in its Intern and Residents cost center. The vast majority of what the Provider construed to fall under teaching time were the hours physicians spent on teaching supervision and administration. These categories were accepted by the Intermediary in the past to support salary allocations. In past years the Intermediary had allowed all of the Provider's physicians salary costs, presumably because they were recognized as direct costs of programs contributing to the quality of patient care.

The Provider contends that the Intermediary has imposed stricter documentation requirements on a retroactive basis. Although the Intermediary did not accept the Provider's documentation as adequate, it made all of its adjustments based on the Provider's Hospital Based Physician's Time Allocation forms[4] which broke out services to the hospital in the following categories: teaching, research, administration, supervision, hospital services, services of general benefit to all patients, and patient services not meeting Part B criteria.

In addition the Provider points out that it used the same physician allocation forms to conduct time studies for two weeks for each quarter of fiscal year 1984. This allocation form comported with a November 3, 1983 letter from the Intermediary, in which the Intermediary

[4]Exhibit P-7

recommended time studies, but provided no format.[5] The Provider relied on the same format accepted by the Intermediary in the past and engaged in diligent efforts to complete the study.

In Good Samaritan, the provider had each physician fill out a time report of not less than two weeks for each quarter of the fiscal year. The time reports established that 100 percent of their time was spent engaging in reimbursable Part A activities. The provider argued that 100 percent of the time was teaching physician duties, including patient care, education and research. Good Samaritan, 873 F. Supp. at 1091-92. The district court held that there was no need to break down Part A time subcategories further, and the intermediary's reclassification of the GME costs, based on the purported inadequate breakdown, was reversed. Id. Likewise, in the case at bar, the Provider claimed physician compensation as part of its GME costs in its 1984 Medicare cost report in accordance with records maintained under the standards and guidelines accepted at that time. Therefore, the Intermediary's reclassification of these costs should be reversed.

The Provider points out that it informed its Intermediary on January 20, 1987, that it's teaching physicians, except for payroll pathologists and contract primary care physicians, provide services solely to the Provider.[6] This means that with the exception of payroll pathologists and contract primary care physicians, the Provider reimbursement for its teaching physicians was attributable to Part A provider services. Under 42 C.F.R §405.481 (d) as long as a provider certifies that the physician compensation is attributable solely to the physicians' services to the provider and the physician personally bills his patient services there is no requirements for allocation agreements or underlying time records.

Issue - 2 Teaching Compensation Contract Physicians

The Provider argues that the Intermediary's adjustment of approximately 88% of the costs claimed by the Provider in its base year cost report for contract physicians, in the same manner it had done for payroll physicians is not correct. For the same reasons articulated in prior contentions the reclassification of the contract physician cost is incorrect.

Issue - 3 Teaching Time -Contract Physicians

The Provider contends that time studies were conducted and were consistent with the Intermediary's letter of November 3, 1983. There was appropriate documentation maintained individually by each physician and signed by them or their department head. Sample completed time study forms for the contract physicians are at Exhibit P-12. The Provider points out that the Intermediary apparently sought additional documentation in support of these time studies, namely, contemporaneous daily physician time logs. The Provider argues

---

[5]Exhibit P-10

[6]Exhibit P-11

that the Intermediary has chosen to create requirements beyond those specified in the Medicare statute and regulations. The Provider points out that in Good Samaritan it was determined that "we do not require the maintenance of daily logs or time records to support provider services rendered by physicians."[7]

The Provider contends that at a minimum, the $505,053 in costs that the Intermediary agreed were attributable to "teaching" time should be allowed. The Intermediary cited as authority for its adjustment HCFA Pub. 15-1 §2104. This section dealing with noncovered costs, is inapposite. Educational activities include training programs that contribute to the quality of caring for Medicare patients. The skills and training provided by teachers is an inherent aspect of these educational programs. Through these teachers, the quality of patient care is enhanced. The graduate training program cannot operate without teaching physicians. Therefore it would defy common sense to disallow these salary costs of teachers.

The Provider argues that all of the 1984 allocations ($4,836,972) supported by time studies, should have been accepted by the Intermediary. The Provider points out that it conducted a time study in 1995. The time study was conducted for a three week period in February and is supported by daily calendar entries, and breaks down teaching activities into more specific categories; supervision of interns and residents, administration of residency program, teaching of interns and residents, and GME-related autopsies. Under that later analysis, approximately 28.5 percent of the teaching physicians compensation (or $1,378,537) is attributable to teaching activities.[8]

The Provider contends that the Intermediary's refusal to consider a subsequent time study in the course of the base year audit of GME costs runs counter to HCFA's explicit instructions to intermediaries to relax the time record requirements in this context. HCFA guidelines permit a three-week time study to be used for calculation of an appropriate average per resident amount. 55 Fed Reg at 36,063-36,065[9] See also Abbott Northwestern Memorial Hosp. v. Blue Cross & Blue Shield Assn., HCFA Administrators Decision Feb. 2, 1995 Medicare and Medicaid Guide (CCH) ¶43,136. The Provider's institution of a time study was delayed because of the limitations placed on it by the Intermediary. The Intermediary would not accept any subsequent time study to verify all claimed costs, but only those costs that the Intermediary recognized as teaching; which was approximately twelve percent of the claimed costs. Even if the Intermediary was correct in rejecting the 1984 documentation and even if the Intermediary was correct in rejecting the 1984 breakdown of physician activities as allowable direct GME activities, the Intermediary was required to consider documentation from a subsequent year time study to support all claimed costs.

---

[7]Exhibit P-13

[8]Exhibit P-14

[9]Exhibit P-8

The Provider argues that 42 C.F.R.§ 413.86 addresses requests that reclassified GME costs be included in a hospital specific rate for purposes of determining reimbursement under the prospective payment system. That provision has no bearing on any time limits to submit a three week time study. The Provider further contends that the time study was timely and the Intermediary's basis for rejecting it is without merit.

The Provider argues that HCFA Pub. 15-1 § 2313.2 which does not address time studies, cannot be a requirement for physician time records, as expressly stated in HCFA Pub. 15-1 § 2182.3E That section states:

> Where providers decide to employ time studies techniques to substantiate either the allocation of physicians' time to services or the actual provider services hours figure used in the RCE computation, the provider may choose to employ the methodology described in subsection 2313.2E, Special Applications, but the provider may not be required by the servicing intermediary to utilize that specific methodology.

Id.

The Provider argues that the Intermediary's reliance on other decisions for rejecting the time study are incorrect. For example, the Intermediary states that two HCFA Administrator's decisions have upheld an intermediary's rejection of a subsequent time study because of a lack of contemporaneous and auditable documentation in the base year.[10] The purpose for allowing time studies is to verify costs where there is no contemporaneous documentation. Moreover, the cases cited by the Intermediary are readily distinguishable in that they involved providers that were attempting to add new costs to the GME base period, which is not the case here. Providence Med. Ctr. v. Blue Cross & Blue Shield Assn., HCFA Administrator Dec. July 30, 1995 Medicare and Medicaid Guide (CCH) ¶43,690;[11] Presbyterian Med. v. Aetna Life, Medicare and Medicaid Guide (CCH) ¶ 43,691. HCFA Administrator Dec. Aug 7, 1995[12]. The Provider points out that it is not seeking to use the subsequent time study to add costs to its base year; it is only trying to verify previously claimed costs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary presents the following arguments which apply to all three of the issues. The Intermediary points out that in the instructions for implementing Medicare program

---

[10] (Exhibit I 15-17)

[11] Exhibit 1-18

[12] Exhibit I-14

payments for GME costs, physician compensation costs relate to four general categories based on the time spent by the physicians in activities relating to each category;

1- Physicians administrative and supervisory services to provider
2- Physicians approved educational activity services to the provider
3- Physicians services to individual patients
4- Nonallowable costs.

The Intermediary argues that the Provider was responsible for distinguishing between the costs includable in category 1 and the costs includable in category 2. This is not a new responsibility for the Provider. HCFA Pub. 15-1 § 2108.1 states in part:

> [m]any providers retain physicians on a full-time basis in, for example, the fields of pathology, physiatry, anesthesiology, radiology, and in many instances (especially in teaching hospitals) in other fields of medical specialization as well. Any one of these physicians may be engaged in a variety of activities including teaching, research administration, supervision of professional or technical personnel, services on hospital committees and other hospital wide activities, as well as direct medical services to individual patients...,
>
> To make payments under the health insurance program, it is necessary todistinguish between the medical and surgical services rendered by a physician toan individual patient, which are reimbursable under Part B on a reasonable chargebasis, and provider services (including a physician's services for the provider)
> which are reimbursable on a reasonable cost basis, generally under Part A.

HCFA Pub. 15-1 § 2108.1.

> [o]rdinarily the compensation paid to the physician is for all services he performs, in proportion to the time he devotes to each activity. It is a primary obligation of the provider and provider based physician to mutually agree upon the allocation of compensation for the provider-based physician to the time he spends in his various activities, and to communicate this information with supporting materials to the provider's intermediary. the supporting material should include a written explanation of the basis for the allocation agreement....

HCFA Pub. 15-1 § 2108. 1 B3.

The Intermediary argues that the Provider did not submit auditable contemporaneous documentation for verification of its as -filed claimed GME expense, nor did it submit an adjustment of its as filed time studies from a subsequent fiscal year timely in accordance with the provisions of 42 C.F.R.§ 413.86. The Medicare regulations at 42 C.F.R§§ 413.20 and 413.24 require providers to maintain auditable and verifiable financial and statistical records from which Medicare program costs can be determined.

The Intermediary points out that in Providence Medical Center v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 95-D38, affirmed HCFA Administrator decision July 30, 1995 Medicare and Medicaid Guide (CCH) ¶ 43,690, the Board held that the intermediary properly excluded emergency room teaching expenses from a provider's base year GME costs. In Providence the provider made no specific request to include the costs during the 1990 GME audit and did not claim the costs in its as-filed 1984 cost report. In 1993, subsequent to the issuance of the NAPRA, the provider submitted a current time study to support its claim that it had incurred emergency room teaching physician expense during the base year. Inclusion of these costs as GME expense would significantly increase the APRA. However, the PRRB held that the results of a 1993 time study did not meet the requirements of § 413.20 and § 413.24 that the cost classifications be supported with adequate records. The lack of contemporaneous documentation was sufficient to deny the providers claim for a recalculation of its APRA. A similar outcome is warranted in this appeal.

The Intermediary points out that in Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Company, PRRB Dec. No. 95-D41 was reversed. See Medicare and Medicaid Guide (CCH) ¶43,692. The Intermediary refused to adjust a provider's APRA on the basis that the provider submitted a time study completed after the base year to support its claim that the costs of a number of teaching physicians had been misclassified. The Board held that the teaching physicians' costs should have been reclassified from operating costs to the GME cost center, because 42 C.F.R.§ 413.86 requires an intermediary to determine a provider's base year APRA as accurately as possible. The provider argued that the costs at issue had been included in the base year cost report, but not in the GME cost center. Therefore, the use of the 1990 time studies was appropriate in view of the lack of GME base year documentation as a result of providers having followed HCFA's record retention rules.

The Intermediary points out that the HCFA Administrator ruled that HCFA specifically advised providers in a 1990 federal register, 55 FR 36063,[13] that a time study results or data from later years could not be used to increase or add to physician compensation costs originally designated in the GME cost center. Because the Provider failed to document its claim for increased physician compensation costs with contemporaneous documentation required by the regulations, the PRRB's decision was reversed. As in Presbyterian, the

---

[13] Exhibit I-15

Intermediary's refusal of the Provider's request to reclassify the physician compensation costs in dispute to the GME cost center based on 1995 time studies for purposes of determining the Provider's APRA was proper.

The Intermediary points out that both the courts and the HCFA Administrator have affirmed a total disallowance of claimed expense in the absence of contemporaneous, auditable and verifiable time records. The importance placed by the Secretary on maintaining adequate, auditable, and verifiable documentation in support of claimed costs has been recognized by the courts and the HCFA Administrator. Daviess County v. Bowen, 811F. 2d 338 (7th Cir. 1987).[14] In Daviess County the Board's decision to allow fees paid by a hospital for physical therapy services delivered in 1979 and 1980[15] was upheld where a provider failed to maintain appropriate time records. The district court's decision allowing reimbursement was reversed, and the Secretary's decision to completely deny reimbursement in the absence of the required records was affirmed. Id.

The Intermediary points out that in Bladen County Hospital v. Blue Cross and Blue Shield Association et al., HCFA Administrator decision November 1, 1985 Medicare and Medicaid Guide (CCH) ¶ 35,010, ¶ 35,046[16] the absence of adequate records, even if secondary sources are relied upon in an attempt to fulfill Medicare's record keeping requirements, was sufficient to disallow a provider's claim for reimbursement of physical therapy costs in full. See also Central Medical Center and Hospital v. Blue Cross and Blue Shield Association et al, PRRB Dec. No. 91-D13[17] Medicare and Medicaid Guide (CCH) ¶ 39,019.

In Central Medical Center, a hospital failed to maintain time records that were adequate to support physician compensation in accordance with Medicare's record keeping requirements, or to support its claimed allocation between Part A and Part B services. The Board affirmed the intermediary's adjustment eliminating 100% of the cost claimed by the hospital for house staff physicians. The Intermediary contends that similarly the Board should affirm the Intermediary's refusal to increase the Provider's APRA.

The Intermediary argues that the Provider has failed to present contemporaneous, auditable and verifiable documentation for an increase in its GME base year costs in violation of the regulations and Medicare program guidelines. The Intermediary points out that its action is further supported by Harrisburg Hospital v. Blue Cross and Blue Shield Association et al.,

---

[14] Exhibit I-19

[15] Exhibit I-20

[16] Exhibit I-21

[17] Exhibit I-22

HCFA Administrator decision, April 18, 1996.[18] Medicare & Medicaid Guide (CCH) ¶ 44,058, ¶ 44,419.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

1395ww(h)	- Payments for direct graduate medical education costs.

2. Regulations:

§§405.1835-.1841	- Board Jurisdiction
§405.1885	- Reopening
§405.481(d)	- Allocation of Physician Compensation Costs
§413.20	- Financial Data and Reports
§413.24	- Adequate Cost Data and Cost Finding
§413.85(g)	- Cost of Educational Activities
§413.86 et seq	- Direct Graduate Medical Education Payments

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

§2104	- Unallowable Costs Related to Patient Care
§2108.1 et seq.	- Reimbursement for Services by Provider-Based Physicians
§2182.3E	- Services of Physicians in Providers
§2313.2	- Special Applications

[18] Exhibit I-23

4. Cases:

Good Samaritan Hosp. v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 93-D79, August 26, 1993, Medicare and Medicaid Guide (CCH) ¶41,693. Good Samaritan Hosp. v. Shalala, 873 Supp. 1083 (S.D. Ohio 1994).

Barnes Hospital v. Mutual of Omaha Insurance Co., PRRB Dec. No. 94-D38, May 31, 1994, Medicare and Medicaid Guide (CCH) ¶42,420.

Abbott Northwestern Memorial Hosp. v. Blue Cross and Blue Shield Assn., HCFA Administrator Decision Feb. 2, 1995, Medicare and Medicaid Guide (CCH) ¶43,136.

Providence Med. Ctr. v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 95-D38 Medicare and Medicaid Guide (CCH) ¶43,690, HCFA Administrator Decision July 30, 1995 Medicare and Medicaid Guide (CCH) ¶43,691.

Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Company, PRRB Dec. No. 95-D41, reversed. HCFA Administrator Decision August 7, 1995, Medicare and Medicaid Guide (CCH) ¶43,691.

Daviess County v. Bowen, 811 F. 2d 338 (7th Cir 1987).

Bladen County Hospital v. Blue Cross and Blue Shield Association et al, HCFA Administrator Decision, November 1, 1985, Medicare and Medicaid Guide (CCH) ¶ 35,010, 35,046.

Central Medical Center and Hospital v. Blue Cross and Blue Shield Association et al, Medicare and Medicaid Guide (CCH) ¶39,019.

Harrisburg Hospital v. Blue Cross and Blue Shield Association et al, PRRB Dec. No. 91-D13, HCFA Administrator Decision, April 18, 1996 Medicare and Medicaid Guide (CCH) ¶44,058, ¶44,419.

Central Medical Center and Hospital v. Blue Cross and Blue Shield Assn. et al, PRRB Dec. No. 91-D13, Medicare and Medicaid Guide (CCH) ¶39,019.

5. Other

55 Fed. Reg. P 36,063-36,065 (September 4, 1990).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board finds that the Intermediary improperly reclassified the teaching costs of the payroll physicians, and the contract physicians from GME costs (interns and residents cost center) to the adult and pediatrics cost center. The Board also finds that the Intermediary's disallowance of the teaching time spent by the contract physicians was improper.

The Board finds that the Provider's 1995 time study can be used to allocate its GME costs. The Board finds that the time study conducted in February, 1995, for a three week period properly breaks down teaching activities into specific categories of supervision of interns and residents, administration of residency program, teaching of interns and residents, and GME related autopsies. The Board finds that the 1995 time study shows that 28.55 of teaching physicians' 1984 compensation or $1,378,537 is attributable to teaching activities, as indicated by the summary of the time study.[19]

The Board finds that the time study although conducted in 1995 (five years after the original time study) properly accounts for the GME costs. The 1995 time study breaks down the time spent in supervision, administration and teaching, which allows for a proper determination of the teaching time. The Board is aware of the importance placed by the Secretary on contemporaneously maintaining adequate, auditable and verifiable documentation in support of claimed costs. However, in this situation the Board finds that since the Provider did have a teaching program, and should be reimbursed for is teaching costs, the best evidence of the allocation of these costs would be the 1995 time study.

The Board finds that the Provider did not follow the Intermediary's advice and the times study allocations were late. The Board finds that there were allocations for 1984. However, these allocations did not break out supervision of interns and residents. Quarterly time sheets were in evidence showing quarterly time studies. However, these time studies were not as complete as the 1995 study. Therefore, the best evidence in the record was the 1995 time study. The Board therefore concludes that the time study should be used to allow the Provider the amount of 28.5% of its GME costs.

The Board notes that in Good Samaritan Hospital v. Shalala, 873 F. Supp 1083 (S.D. Ohio, 1994). The court stated in part:

> [t]he secretary's interpretation of Medicare regulations as requiring a breakdown of Part A physician services for the period in question is not reasonable, and the reclassification of Plaintiff's GME costs based on Plaintiff's failure to perform such a breakdown was not proper.

---

[19] Exhibit P-14

Id. The court continued:

> [f]urther, although the regulations mandate that a provider supply cost data, nowhere is it spelled out exactly what data is required. It is reasonable therefore, for the plaintiff to rely on the March 1985 Bulletin in order to determine what financial information and data it was required to maintain... a provider was required to do the following in order to be reimbursed for physician compensation costs: (1) submit a written allocation agreement, that specifies the amounts of time the physician spends for Part A, B, and C, respectively, and (2) have each physician complete a time report... for a period of not less than two weeks for each quarter during the fiscal year...

Id. The court concluded :

> [d]espite the fact that the regulations did not require a breakdown of Part A time, the Secretary argues that the provider knew of the breakdown requirement since some physicians compensated by plaintiff did break down their time under Part A and the allocation agreement submitted by Plaintiff listed subcategories under Part A. However, it is not reasonable to impute to Plaintiff knowledge of a requirement to break down Part A time when neither the regulations not the Reimbursement Bulletin set forth such a requirement. Accordingly, the Secretary's interpretation of the regulations as requiring a breakdown of Part A time is not reasonable and the reclassification of GME Costs on the basis of Plaintiff's failure to perform such a breakdown was not proper.

Good Samaritan Hospital v. Shalala, 873 F. Supp. 1083 (SD Ohio, 1994).

In the case at bar, the Board concludes that the Provider did have a time study, although it was performed years after the cost reporting period in contention, nevertheless the time study indicates that there was teaching performed at the hospital. Therefore, the Board concludes that the Provider is entitled to some amount of reimbursement and that amount should be based on the 1995 time study. The Board agrees with the Provider's alternative method of reimbursement that the 1995 time study be used as a basis for recomputing the per resident amount so that it includes 28.5% of the as-filed teaching physician compensation costs, or $1,378,537, the exact amount to be confirmed by the Intermediary.

DECISION AND ORDER:

Issue No. 1- Reclassification of Compensation of Payroll Physicians

The Intermediary's reclassification of compensation for payroll physicians was improper. The Intermediary's adjustment is reversed.

Issue No. 2 - Reclassification of Teaching Compensation For Contract Physicians

The Intermediary's reclassification of teaching compensation for contract physicians was improper. The Intermediary's adjustment is reversed.

Issue No. 3 - Disallowance of Teaching Time Spent by Contract Physicians

The Intermediary's disallowance of teaching time spent by contract physicians was improper. The Intermediary's adjustment is modified.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. , Esq.
Charles R. Barker
Date of Decision: January 26, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman