PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D23

PROVIDER -
United Hospitals Medical Center
Newark, New Jersey

Provider No. 31-0062

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of New Jersey

DATE OF HEARING-
October 28, 1999

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 96-1736

INDEX

ISSUES:

1. Was the Intermediary's calculation of the number of maintained beds proper?

2. Was the Intermediary's adjustment excluding certain resident Full-Time Equivalents (FTEs,) proper?

3. Was the Intermediary's adjustment excluding certain allowable fringe benefits proper?

4. Was the Intermediary's adjustment disallowing certain amounts related to contract labor proper?

5. Was the Intermediary's adjustment disallowing certain amounts related to Part B physician salaries and hours proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

United Hospitals Medical Center ("Provider") was a Medicare certified acute care hospital located in Newark, New Jersey. The Provider has filed a petition pursuant to Chapter 11 of the Bankruptcy Code. That matter, filed on February 19, 1997 is pending as case number 97-21785 (WFT). On September 26, 1995, Blue Cross and Blue Shield of New Jersey ("Intermediary"), sent the Provider a Notice of Program Reimbursement. (NPR). The Provider disagreed with the Intermediary's determination and on March 22, 1996 appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F. R. §§1835-.1841 and has met the jurisdictional requirements of those regulations. The effect on Medicare reimbursement is approximately $506,000.

The Provider was represented by Joseph D. Glazer Esq. of Reed, Smith Shaw & McClay LLP. The Intermediary was represented by Eileen Bradley of the Blue Cross and Blue Shield Association.

Issue I -Number of Maintained Beds:

FACTS:

The Provider's 1993 cost report Worksheet S-3 Part 1, indicates that there were 329 maintained beds. The Intermediary reviewed the supporting documentation which revealed that there were 359 maintained beds. The Provider contended that a wing was closed during the cost reporting period and that the 30 beds were out of service, The Intermediary did not receive any documentation to support the Provider's contention that a wing was closed and therefore adjusted the bed count to include the 30 beds.

PROVIDER'S CONTENTIONS:

The Provider contends that in calculating its Indirect Medical Education ("IME") adjustment, the Intermediary improperly added 30 beds to the available bed size count. These additional 30 beds should not have been included, because they related to certain sections of the Medical Center that had been closed.

The Provider points out that HCFA Pub. 15-1 § 2405.3G provides in relevant part that in calculating a Provider's IME adjustment:

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). Thus, beds in a completely or partially closed wing of the facility are considered available only if the hospital put the beds into use when they are needed. The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes in the size of a facility as beds are added to or taken out of service.

§2405.3G

The Provider contends that the unit comprising the 30 beds at issue had been closed at year end 1993. This was effectuated by a transfer of patients to a renovated section, 7-North, which was out of service since August of 1992. Several documents, including excerpts from the Provider's October 1992 Board minutes, refer to the closed 7-North unit. This 41 bed unit was reopened on or about December 20, 1993 after being out of service for the entire year.

The Provider points out that another unit, 3-west, was a general adult medical surgical unit of twenty seven beds. Eleven of the twenty seven beds were converted to Pediatrics due to volume increases. The remaining sixteen adult beds are not listed on a January 1993 survey performed by external architects planning renovations to the Children's Hospital.

The Provider maintains that the reduction in licensed beds from 429 to maintained beds of 329 in 1993 were as follows:

Licensed Beds in 1993		429	
Less:			
	Removal of SDS Beds	16	
	4-West unit closed prior to 1993	27	
	7-North unit closed August 1992	41	
	3-West Reduction January 1993	16	100
1993 Maintained			329.[1]

INTERMEDIARY'S CONTENTIONS;

The Intermediary contends that due to a lack of documentation to support a wing being closed, it properly included the 30 beds in the calculation of the Provider's maintained beds. The Intermediary points out that it never received the Provider's letter which the Provider contends documented the closing of the wing.

The Intermediary argues that if the Provider did produce evidence that there were 30 beds taken out of service during the 1993 cost reporting period, these beds would still have to be included in the maintained bed calculation if the Provider made no adjustment to remove the depreciation for these beds as required in Administrative Bulletin #1841, 88.01.[2] This bulletin clearly states that "[a] wing is considered permanently closed if the area in which the beds are contained is not included in the hospital's depreciable plant assets subject to capital-related cost reimbursement during a cost reporting period,...". Since no such adjustment to the depreciable assets was made, these beds must be included in the Provider's count of maintained beds. The Intermediary points out that 42 C.F.R. §413.134(a) refers to allowable depreciation for buildings and equipment used in the provision of patient care.

Issue-2 Full Time Equivalents

FACTS:

The Provider submitted 103 FTEs related to reimbursement for Graduate Medical Education. Upon audit the Intermediary adjusted total Interns/Residents FTE's to 98.5.[3]

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[1] Provider exhibit 6

[2] Intermediary Exhibit 4

[3] Intermediary exhibit 2, Provider exhibit 8

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly removed a total of 2.72 Full-Time Equivalent ("FTE") residents from the calculation of the Provider's Graduate Medical Education adjustment. The Intermediary removed 0.16 FTEs due to residents not being reported on the Interns and Residents Information System (IRIS) report. The rotation schedules, however, showed that the residents did work at the Provider for the specified months. The Intermediary also removed 2.56 FTEs due to residents being weighted for staying in the residency program for longer than required in the Accreditation Letter.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that as part of its normal auditing procedures, it uses the IRIS. The IRIS listing is submitted with the cost report each year and is a complete listing of the Interns/ Residents who worked at the facility during the given cost report year. The 0.16 FTE's in dispute are related to two residents who rotated to the Provider from another major teaching hospital. These two residents rotated through the Provider for one month each, according to the Provider. However, these two residents did not appear on the Provider's IRIS listing nor did their names appear on any of the Provider's rotation schedules. The only documentation that the Provider did produce was the invoice showing these two residents' names. The invoices did not support the fact that these residents actually worked at the Provider's facility in the month claimed.

The Intermediary points out that in accordance with the 54 Fed. Reg. 40,206 Sept. 29, 1989,[4] which describes the per resident amount method of reimbursing for Graduate Medical Education, the resident must be working at the facility in order to be counted as part the hospital's of GME FTE'S. The invoice provided as documentation merely shows that the Provider was billed for the residents in question, but does not prove these residents actually worked at the facility.

The Intermediary contends that if the remainder of the Provider's Interns/residents were verified to a source document (i.e. rotation schedule and/or IRIS listing) then the documentation for these two residents should have been available. The Intermediary further points out that 42 C.F.R. §413.24 requires that adequate, auditable cost data be obtained from providers to verify claimed costs. The Provider has not complied with this regulation.

The Intermediary contends that in accordance with Fed. Reg. 40,206 (Sept. 29, 1989), a resident FTE must be weighted at 0.5 if the Resident exceeds the initial residency for that program. The Program year for each of the residents in question was verified from the audited Provider IRIS listing. The Provider had Interns/Residents that were in a program year that exceeded the initial residency period, therefore the Intermediary weighted their time spent at the facility by 0.5.

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[4] Intermediary exhibit

Issue-3 Fringe Benefits:

FACTS:

The Provider submitted $171,415 in expense related to uniform allowance as part of their Fringe Benefits on Worksheet S-3 Part 11. The Intermediary excluded this expense from the Provider's Fringe Benefits.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly excluded from worksheet S-3, Part 11, Line 6, Fringe Benefits for employee uniforms. The uniform allowance costs were required by contract and were separately identified in the Provider's payroll register by a separate deduction code, and therefore included in the salaries reported on the W-2 form.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly excluded the expense related to uniforms for union and non-union employees. This adjustment was made in accordance with the HCFA listing of allowable and nonallowable Fringe Benefits[5]. The listing clearly indicates that a uniform allowance is not an allowable Fringe Benefit. The Intermediary also contends that the Board should not accept Jurisdiction over this issue as the Provider did not exhaust its administrative remedy to correct wage errors as described in the 61 Fed. Reg. 46,179 (Aug. 30, 1996).[6]

Issue-4 Contract Labor:

FACTS:

The expense in question relates to Vascular lab, Diagnostic x-ray, Eye clinic and New Community Clinic services. The Provider supplied its purchase journal report to document these expenses. The Provider did not submit actual invoices to validate these expenses.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly excluded from worksheet S-3, Part 11, Line 4, amounts related to contract labor for Vascular laboratory services, X-ray diagnostic services, Eye clinic

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[5] Exhibit I-10

[6] Intermediary Exhibit 12

and New Community Clinic services, which are patient related contract services. The cost was identified in the Cumulative Purchase Journal by object code and a description. The Provider contends that the Intermediary's exclusion of the above referenced contract labor items negatively impacted the Provider's Wage Index.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that HCFA Pub. 15-2, § 2806.2 indicates that allowable contract labor to be reported on Worksheet S-3 Part 11 has to be related to patient care. While the Provider's purchase journal does represent an acceptable source to verify the actual payment of such services, it does not represent an acceptable source to determine if the services were related to hands-on patient care. The Intermediary requested copies of the invoices to help in making the determination of whether these services were related to hands-on patient care. However, the Provider could not produce them. The Intermediary contends that it was not able to make an accurate determination as to the nature of these services from the purchase journal account description alone.

The Intermediary argues that the Board does not have jurisdiction over this issue as the Provider did not exhaust its administrative remedy to correct wage errors as described in the Federal Register No. 61 No. 170, August 30, 1996, 46,179.

Issue -5 Part B Physician Salaries:

FACTS:

The Provider submitted a total of $7,965,809 in physician enumeration on their Worksheet A-8-2. This amount is comprised of $6,944,295 in Part A Provider Component and $1,021,514 in Part B-Professional component. As a result of auditing the Provider's hospital based physicians, the Intermediary adjusted the submitted amount to reflect all physicians as 100% Part B. The adjustment was made as the physicians did not complete acceptable time allocations for the 1993 cost reporting year as required by 42 C.F.R. §405.481.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly excluded from worksheet S-3, Part 11, Line 2. 1 0 and Line 10, Part B physician salaries and hours. The Intermediary did not accept the 1993 Physician Time Allocation Surveys that were prepared and signed by each physician. The surveys were divided into the following three categories:

1. Provider Activities -teaching, administrative and other;
2. Professional Services- direct patient care;
3. Non-covered Activities- funded research.

Salaries and hours are captured in the 1993 Payroll Register. The Provider estimates that the exclusion of the referenced physician salaries and hours substantially reduced the Provider's reimbursement.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the documentation submitted to support the physicians time allocations was only a summary sheet showing the number of hours the physicians' spent doing each of the tasks as listed on the Provider's pro-forma sheet. These documents did not indicate from which time period they were reflective, nor were they in a form that permitted the Intermediary to validate the information as required by 42 C.F.R.§405.481(g)(1). In addition the physicians are required to complete periodic time studies throughout the cost reporting year as set forth in HCFA Pub. 15-1 § 2313.3E. The Provider did not have this documentation.

The Intermediary points out that since the Provider did not have the required documentation, it deemed all hospital based physician time as 100% Part B in accordance with 42 C.F.R.§ 405.481(f)(ii)(2). Therefore, the Intermediary excluded these physician salaries and hours from the total Worksheet S-3 Part 11. In accordance with HCFA Pub. 15-1 §2806.2, all physician Part B cost should be excluded on Worksheet S-3 Part 11.

The Intermediary argues that the Board should not accept jurisdiction over this issue as the Provider did not exhaust its administrative remedy to correct wage errors as described in the 61 Fed. Reg. 46,179 (Aug. 30, 1996).

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§405.481et seq.	-	Allocation of Physician Compensation Costs
§§405.1835-.1841	-	Board Hearings
§412.63 et seq.	-	Federal Rates for Inpatient Operating Costs for Fiscal Years After fiscal Year 1984
§413.24	-	Adequate Cost data and Cost Finding
§413.86 et seq.	-	Direct Graduate Medical Education Payments
§413.134(a)	-	Depreciation; Allowance for Depreciation Based on Asset Costs

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

§2313.3E - Periodic Time Studies

§2405.3G - Adjustment for the Indirect cost of Medical Education

§2806.2 - Hospital Wage Index Information

3. Other:

Administrative Bulletin #1841, 88.01

54 Fed. Reg. 40,206 (Sept. 29, 1989).

61 Fed. Reg. 46,179 (Aug. 30, 1996).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented finds and concludes:

ISSUE -1-Number of Maintained Beds:

The Board finds that due to a lack of documentation, it was not able to determine if the beds in question were permanently or only temporarily closed. After reviewing the documentation presented by the Provider, the Board was not able to reconcile the number of beds claimed by the Provider. The Board also finds that there was no depreciation adjustment which indicates that the beds were not permanently closed. Therefore, the Board finds that the Intermediary acted properly in determining the number of beds.

ISSUE -2 Full Time Equivalents:

The Board agrees with the Intermediary's finding that there was not sufficient documentation that the two residents in question rotated through the Provider for one month each. The two residents did not appear on the Provider's IRIS listing not did their names appear on any of the Provider's rotation schedules. The Board finds that the invoice which the Provider produced as documentation did not support the Provider's contention. The Board also finds that the Intermediary acted properly when it weighted the Interns and Residents that were in a program year that exceeded the initial residency period. The Intermediary properly weighted their time spent at the facility by 0.5 as per at 42 C.F.R. §413.86 et seq.

ISSUE - 3 Fringe Benefits:

The Board finds that the evidence in the record indicates that this issue is a wage index issue. Since it is a wage index issue the Board applies the wage index regulation which describes the actions to be taken by the Provider. The Board finds that the provider did not exhaust its administrative remedies and therefore, the Board does not have jurisdiction in this case. The provider should have requested an adjustment in accordance with 42 C.F.R. 412.63 et seq.

ISSUE - 4 Contract Labor:

The Board finds that the evidence in the record indicates that this issue is a wage index issue. Since it is a wage index issue the Board applies the wage index regulation which describes the action to be taken by the Provider. The Board finds that the Provider did not exhaust its administrative remedies and therefore, the Board does not have jurisdiction in this case. The provider should have requested an adjustment in accordance with 42 C.F.R. 412.63 et. seq.

ISSUE - 5 Part B Physician Service:

The Board finds that based on the evidence in the record the issue involves both a direct adjustment to the cost report and an adjustment to the wage index calculation. With regard to the cost report adjustment, the Board does have jurisdiction. The Board finds that although there was some evidence of the Part A doctors activities, the evidence was totally inadequate and therefore the Board finds that the Intermediary's adjustment was correct.

With regard to the wage index adjustment, the Board finds that it does not have jurisdiction of the wage index adjustment as the Provider did not exhaust all of its administrative remedies.

DECISION AND ORDER:

ISSUE - 1- Maintained Beds:

The Provider did not have sufficient documentation to prove that the beds were permanently closed. The Intermediary's adjustment is upheld.

ISSUE -2- Full Time Equivalents:

The Provider did not present sufficient documentation to verify the status of the two residents. The Intermediary's adjustment is upheld.

ISSUE -3- Fringe Benefits:

The Provider did not exhaust its administrative remedies. The Board does not have jurisdiction over this issue.

ISSUE -4- Contract Labor:

The Provider did not exhaust its administrative remedies. The Board does not have jurisdiction over this issue.

ISSUE -5- Part B Physician Service:

A - Cost Report Adjustment:

The Provider did not have sufficient documentation to substantiate the Physician's Part A cost. The Intermediary's adjustment is upheld.

B - Wage Index:

The Provider did not exhaust its administrative remedies. The Board does not have jurisdiction over this issue.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

Date of Decision: March 2, 2000

For The Board

Irvin W. Kues
Chairman