PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D17

PROVIDER –
Natividad Medical Center
Salinas, California

Provider No. 05-0248

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services, LLC - CA

DATE OF HEARING -
June 13, 2002

Cost Reporting Period Ended
June 30, 1997

CASE NO. 00-0544

INDEX

ISSUE:

Was the Intermediary's adjustment to the residents count and Graduate Medical Education payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Natividad Medical Center (Provider) is a city-county facility located in Salinas, California. The Provider was certified for Medicare participation on July 1, 1966. The Provider is entitled to reimbursement for Direct Graduate Medical Education (GME). As part of the calculation reimbursing providers for GME, a determination is made as to the total number of Full Time Equivalent Residents (FTE). The FTE is counted according to the regulation established at 42 C.F.R. § 413.86 (f), which states in part:

(i) Residents in an approved program working in all areas of the hospital complex may be counted.

(ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraph (f)(1)(iii) of this section, in a non-provider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions met:

(A) The resident spends his or her time in patient care activities.

(B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

The Provider reported a residents count of 19.70 FTEs for GME, and also reported a GME per resident amount of $113,761.52 on its as filed cost report for fiscal year ended (FYE) 6/30/97. Based on the audit of the rotation schedule and other documentation furnished by the Provider, United Government Services (Intermediary) excluded from the residents count the time when residents were on "elective away" at the hospital-based skilled nursing facility (SNF), physician offices, and unspecified clinics at different locations.

The Provider disagreed with the Intermediary's adjustment and requested a hearing before the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The amount of Medicare reimbursement at issue is approximately $44,946.

The Provider was represented by Douglas S. Cumming, Esq., The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider points out that 42 C.F.R. § 413.86(f)(3) indicates that the time residents spend in non-provider settings such as physicians' offices is not excluded in determining the number of full time residents if, inter alia, there is a written agreement between the hospital and the outside entity stating that the residents' compensation for training time spent outside the hospital setting is to be paid by the hospital.

The Provider contends that the evidence is uncontested that a written agreement existed through 1995 and again commencing subsequent to the period under appeal.[1] However, during the period in question, the arrangements for residents to work outside the hospital were pursuant to "an understanding or verbal agreement."[2] There does not appear to be any disagreement regarding whether these agreements complied with the requirements of 42 C.F.R. § 413.86(f)(3).

The Provider argues that the arrangements did not change for the years under contention, and that an implied-in-fact contract existed during the intervening years in which no written agreement, as such, was in place. An implied-in-fact contract is determined to exist under circumstances in which a contractual agreement between the parties may be inferred from their acts of conduct. See17Am. Jur. 2d, Contracts §12. For instance, the Uniform Commercial Code (UCC) provides that an agreement may be found by implication from circumstances including the course of dealing of the parties. See,U.C.C. § 1-201(3). Moreover, a written instrument is not itself a contract but rather merely evidence thereof. See, 17 Am. Jur. 2d., Contracts §12, (citations omitted).

The Provider maintains that as occurred in the cost report period in contention, where an agreement expires by its terms and the parties continue to perform as before, an implication arises that they have mutually assented to a new contract containing the same provisions as the old contract. See17 Am. Jur. 2d, Contracts § 605. (citations omitted). Thus, an employee continuing to work after expiration of a definite term is prima facia presumed to continue on the same terms of the old contract, including provisions for compensation. See 53 Am. Jur, Master and Servant § 75.

The Provider contends that the contractual agreement which was in effect through 1995 continued in full force and effect during the intervening period when there was no written agreement between the parties which as such covered those years. Accordingly, the written agreement which was in effect prior and which was expressly put in place subsequent to the period in question should be deemed applicable and to conform with the regulatory requirements.

---

[1] Tr at 63-64.

[2] Tr at 63.

The Provider argues that the courts have held that the relationship between providers and government is in the nature of a contract, the terms of which consist of the statutes and regulations applicable to the government program in question. (citations omitted). In this sense, the requirements of 42 C.F.R. § 413.86 for the existence of a written agreement between the hospital and the outside entities in which residents work constitute a term of the contract between the Provider and the Medicare program. As a result, the doctrine of substantial performance should be applied to this situation. Pursuant to that doctrine, the law looks to the spirit of the contract, not the letter of it, and thus the question is not whether the parties have literally complied with the contract requirements but whether they have substantially done so. See 17 Am. Jur. 2d, Contracts § 631, Citing, inter alia. (citations omitted). The courts have held that substantial compliance with plans and specifications is sufficient to constitute substantial performance. (citations omitted).

The Provider argues that by virtue of having entered into a written agreement both prior to and subsequent to the period in question, coupled with the continuing performance on the same basis throughout that entire time frame, the Provider substantially complied with the requirement of a written agreement, and thus must be deemed to have substantially performed what are in essence its contractual obligations to comply with applicable Medicare regulations in order to receive reimbursement.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly determined the GME payments, pursuant to 42 C.F.R. § 413.86, PRM §§ 3630.1 and 3633.4, and the MIM13-4 § 4198, exhibit A-9. The Intermediary completed its audit using the established audit program and the GME tracking report relied upon by all fiscal intermediaries, since it shows the updated amounts and limits set by CMS. The Intermediary also adjusted the residents count based on the IRIS data, rotation schedules and other information furnished by the Provider. The Intermediary ensured that the residents shown therein are not counted as more than one FTE, and only the portion of FTE that relates to the Provider is counted.

The Intermediary points out that since certain residents were on elective away time or spending time at other hospitals or offsite clinics, the Intermediary properly reduced the reported count based on the proportion of time the residents worked at the hospital to the total time worked. The Intermediary contends that its determination was in accordance with 42 C.F.R. § 413.86, which states in part:

> (f) Determining the total number of FTE residents. (1) Subject to the weighting factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:
>
> (i) Residents in an approved program working in all areas of the hospital complex may be counted.

(ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or … in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of allowable time worked compared to the total time necessary to fill a full-time internship or residency slot.

(iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:

(A) The resident spends his or her time in patient care activities.

(B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

* * * * *

(h) Determination 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; or

(ii) Before July 1, 1986, received the certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight

> determined under the provisions of paragraph (g) on this section . . . .

The Intermediary contends that the Provider did not demonstrate with compelling or convincing evidence that the Intermediary's determination was inconsistent with the Provider's records or the referenced program regulation and instructions. The Provider did not clarify the nature of the "elective away" and demonstrate that such rotation was a requirement of the accredited educational program. The Intermediary maintains that it has no basis to include the related FTEs for "elective away" in the count. The Intermediary argues that the Provider did not demonstrate that counting the "elective away" would fall under 42 C.F.R. § 413.86(f)(1)(iii), and that it has met all the aforementioned conditions. The Provider also has not supported any basis for the correction of time spent at other acute care hospitals.

The Intermediary contends that it properly determined the GME payments, pursuant to 42 C.F.R. § 413.86, PRM –2 §§ 3630.1 and 3633.4 and MIM-4 § 4198, Exhibit A-9; and that it properly observed the audit guidelines for determining the allowable GME payments, pursuant to MIM-4 § 4198, Exhibit A-9--- Exhibits for PPS Audits, Direct Medical Education Costs.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, parties' contentions and evidence submitted finds that the Provider did not meet the requirement of the regulation at 42 C.F.R. § 413.86 which requires a written agreement between the hospital and the outside entities. Therefore, the Intermediary's adjustment of the Provider's FTE count was proper.

The Board finds that there was no written agreement between the Provider and the outside entities. Although the Provider contended that it had an implied contract which had the same provisions of its former written contract, the Board finds no evidence of a written contract. An implied in fact contract does not rise to the level of a written agreement when required by regulation. The regulation at 42 C.F.R. § 413.86 et seq. requires:

> (C) There is a written agreement between the hospital and the outside entity that states that the residents compensation for training time spent outside of the hospital setting is to be paid by the hospital.

Therefore, since there was no written agreement between the Provider and the outside entities as required by regulation, the Board concludes that the Intermediary properly adjusted the FTE numbers and the associated cost.

DECISION AND ORDER:

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

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Gary B. Blodgett, D.D.S.

DATE OF DECISION: March 6, 2003

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson