PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D2

PROVIDER –
Bournewood Hospital
Brookline, Massachusetts

Provider No. 22-4022

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/Associated Hospital Services of Maine

DATE OF HEARING -
September 11, 2003

Cost Reporting Periods Ended
August 31, 1997
August 31, 1998
August 31, 1999

CASE NOs. 99-3609
00-3050
01-2972

INDEX

ISSUE:

Were the Intermediary's adjustments to physician stand-by costs in the routine area correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bournewood Hospital ("Provider") is a 90-bed psychiatric hospital located in Brookline, Massachusetts. The Intermediary disallowed Medicare payments to the hospital for its cost of having physicians on stand-by in the routine area of the hospital. Its basis for the disallowance was that such costs are allowable only in an emergency room. The Provider appealed the adjustments to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The amount of Medicare funds in controversy is approximately $293,000.[1]

The Provider was represented by Carolyn Gabbay, Esq., of Nixon Peabody, LLP. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider's psychiatric unit is reimbursed by Medicare on a reasonable cost basis[2] for all necessary and proper costs incurred in furnishing health services to Medicare beneficiaries. 42 C.F.R. §§ 412.22(b), 412.23. The state's Department of Mental Health ("DMH") regulations require any hospital which admits mentally ill persons on any admission status other than, or in addition to, voluntary status, to be licensed by the DMH. The staffing requirements for DMH licensure provide that a hospital must have a physician on staff at all times.[3] The Provider points out that the Medicare program requires, as a condition of program participation, that a psychiatric hospital be licensed by the state.[4] Thus, the Provider contends it has no discretion whether to provide continuous physician on-site presence.

The Provider further contends that the regulation allowing reimbursement for physician availability services in the emergency room should not be read to limit reimbursement to services provided exclusively in that setting. The Provider points to County of Los Angeles v. Shalala, 192 F.3d 1005, 1022 (D.C. Cir. 1999) citing a long line of precedent that an agency acts arbitrarily when it fails to give adequate reasons for treating similar situations differently.[5] Provider argues that comparable services must be reimbursed as

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[1] Provider's Supplemental Position Paper at 2.

[2] Generally, hospitals are paid by Medicare based on prospective payment rates ("PPS"). However, some separate units of hospitals, such as the psychiatric unit in this case may be PPS exempt.

[3] Provider Exhibit 1.

[4] Provider Exhibit 2.

[5] Provider Exhibit 9.

reasonable costs even though furnished in another provider setting. The Provider also references Pelham Bay General Hospital v. The Travelers Insurance Co., HCFA Admin. Decision, August 4, 1981, Medicare and Medicaid Guide (CCH) ¶ 31,506 ("Pelham Bay") in which the Administrator found that although physician availability services were furnished in the intensive care unit, rather than in the emergency room, it was insufficient by itself to find that the claimed costs were not allowable.[6]

The Provider also contends that the rationale set forth in CMS Pub. 15-1 § 2109 for reimbursing physician availability costs in the acute hospital emergency room applies with equal force in this case. Wide variations in utilization also occur in a psychiatric hospital because there are voluntary and involuntary admissions occurring twenty-four hours per day, making it impossible to predict volume.

In support of this emergency function, the Provider has examination rooms designated for the physician on site to triage and treat new admissions at whatever time of day or night a patient may present. Although these examination rooms do not constitute an emergency department as such, CMS recognizes that lack of an established emergency department is not an indication that emergency services are not provided by a hospital. For example, under the Emergency Medical Treatment and Active Labor Act ("EMTALA") Interpretive Guidelines, § 489.24(a),[7] CMS cautions that a psychiatric hospital providing emergency services for psychiatric, medical, or substance abuse emergency conditions is subject to the requirements of EMTALA, whether or not the hospital has a dedicated emergency department. CMS specifically addressing psychiatric hospitals, states that:

> Although these [psychiatric] hospitals do not have organized emergency departments, they [i.e., facilities that offer 24-hour psychiatric services, including admissions on other than a voluntary basis] are presenting themselves to the public as providing care for psychiatric emergencies. We believe that this type of facility must comply with the requirements of section 1867 of the [Social Security] Act and render emergency care.

59 FR 32086 at 32101. [8]

Thus, the Provider argues that the necessity for a psychiatric hospital licensed in Massachusetts to render emergency treatment to individual patients, as and when needed, is the same function for which CMS authorizes reimbursement by Medicare for services provided in an acute hospital emergency department. See CMS Pub. 15-1 § 2109.2.[9] In essence, the physician on site at a Massachusetts psychiatric hospital is providing an emergency room function, albeit for psychiatric emergencies.

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[6] Provider Exhibit 8.
[7] Provider Exhibit 13.
[8] Provider Exhibit 14.
[9] Provider Exhibit 7.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its disallowance of physician stand-by costs was appropriate for several reasons.

1. No linkage between Medicare conditions of participation, state licensing requirements and the Medicare principles of reimbursement

The Secretary has the authority to limit reimbursement. Using that authority, the Secretary promulgated 42 C.F.R. § 415.55(a)(2) which specifically denies reimbursement for stand-by costs outside an emergency room. In the instant case, the Provider clearly does not have an emergency room on its premises. Secondly, the Provider has not cited any regulation that automatically makes the cost of meeting a condition of participation or meeting a state licensure requirement a reimbursable cost. The Intermediary points to two cases where the CMS Administrator has ruled that state licensing requirements do not provide a basis for Medicare reimbursement. See 1986 Adolescent Education Group Appeal v. Blue Cross and Blue Shield Association, CMS Administrator Decision, November 4, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,716[10] and National Jewish Center for Immunology and Respiratory Medicine v. Blue Cross and Blue Shield Association, CMS Administrator Decision, April 12, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,737.[11]

2. Documentation Requirements

The Intermediary contends that the Provider has not met the documentation requirements of 42 C.F.R. § 415.60(b)[12] to support its claim that the time spent by stand-by physicians was 100% Medicare Part A. Medicare has distinguished between a physician's professional services furnished to, or on behalf of the providers and physician's professional services furnished directly to patients. The reasonable cost of services furnished to providers is reimbursed under Medicare Part A. Patient services are paid under Medicare Part B on a reasonable charge basis. In the absence of verifiable documentation segregating the Part A costs from the Part B costs, all of the costs must be allocated to Part B as required by 42 C.F.R. § 415.60(f)(ii)(2). None of the Part B costs would be reimbursable through the Medicare cost report. Second, the Intermediary contends that the Provider has not met any of the documentation requirements of CMS Pub. 15-1 §§ 2109.1, 2109.2 and 2109.3.[13] In addition, the Intermediary contends that the Provider did not submit information on Worksheet A-8-2 of the Medicare cost report that is required by CMS Pub. 15-2 § 3615.[14] That information is required to allow the Intermediary to apply the reasonable compensation equivalents ("RCEs") to the physician

[10] Intermediary Exhibit I-18.
[11] Intermediary Exhibit I-19.
[12] Intermediary Exhibit I-20.
[13] Intermediary Exhibit I-16.
[14] Intermediary Exhibit I-13.

compensation, assuming it is reimbursable at all. Absent that information, the Intermediary cannot allow any compensation.

3. The Pelham Decision Is Not Applicable

The Intermediary points out that when Pelham Bay was reversed by the CMS Administrator in 1981, the Administrator noted that no specific regulation prohibited Medicare payment for standby costs for emergency services furnished in a non-emergency room setting. The Intermediary argues that the circumstances are now changed with the issuance of 42 C.F.R. § 415.55 in December, 1995, with an effective date of July 1, 1996. Specifically, 42 C.F.R. § 415.55(a)(2) provides that:

> The services include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency rooms and the services of standby surgical team physicians.

Accordingly, the Intermediary argues that the reasoning that led to a favorable decision in Pelham Bay is not applicable to the case at hand.

4. Expenditures for Stand-By Physicians Were Not Prudent

The Intermediary contends that the expenditures for stand-by costs were not allowable as they did not meet the prudent buyer concept established in CMS Pub. 15-1 § 2103. Any emergencies that arose could have been handled by nearby medical facilities, either in the same town or within a short ambulance ride from the Provider. Secondly, the Provider did not demonstrate that it attempted to procure the least expensive service under the circumstances. Accordingly, the Intermediary contends that the Provider has not met the required burden of proof to show that its decision to pay for around-the-clock physician routine availability services, absent an emergency room, was prudent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence presented and the parties' contentions, finds and concludes that the Provider's physician stand-by costs are not allowable.

The Board finds that, as a PPS-exempt psychiatric unit the Provider is reimbursed on a reasonable cost basis for costs attributable to the psychiatric unit. In the case at hand, the Provider contracts with various physicians to provide required on-site physician presence (i.e., standby costs for emergency services) to comply with Massachusetts' licensure standards. The Provider is seeking to have those costs recognized as necessary and proper reimbursable operating costs under the reasonable cost regulation as defined in 42

C.F.R. § 413.9(b)(2).[15] More specifically, the Provider points to 42 C.F.R. § 415.55 (a)(2) in which Medicare recognizes physician availability costs as allowable costs in hospital emergency departments, provided certain criteria are met. The Provider contends that the rationale set forth in CMS Pub. 15-1 § 2109 for reimbursing physician availability costs in the hospital emergency room applies with equal force in this case. Conversely, the Intermediary asserted that the claimed costs are not allowable in that the Provider does not have a formal emergency room on its premises.

In its review of the cited regulations and manual instructions, the Board finds that neither the regulations nor the manual instructions define the term "emergency room." Looking for alternative guidance, the Board notes that the EMTALA interpretive guidelines state in part:

> [A] hospital with an emergency department is defined in paragraph (b) of this section as one which offers services for emergency medical conditions within its capability to do so. Lack of an established emergency department is not an indication that emergency services are not provided. If a hospital offers emergency services for medical, psychiatric or substance abuse emergency conditions, it is required, within its capability and capacity, to comply with all of the anti-dumping statutory requirements.
>
> If a psychiatric hospital offers services for medical, psychiatric, or substance abuse emergency conditions, it is obligated to comply with all of the anti-dumping requirements of 489.20 and 489.24.

Accordingly, the Board finds that the necessity for a psychiatric hospital licensed in Massachusetts to render emergency treatment to individual patients, as and when needed, is the same function for which CMS authorizes reimbursement by Medicare for services provided in an acute care setting. Since the EMTALA guidance is issued by CMS (the same organization which issued the payments to providers for physician services regulation), the Board finds there is a sufficient basis to conclude that the Provider did provide emergency services to its patients.

Next, the Board finds that it must address the specific documentation requirements set forth in the regulations and CMS manual instructions. First, the regulation at 42 C.F.R. § 415.55(b)[16] states that providers must follow the rules in 42 C.F.R. § 415.60 regarding the proper allocation of physician compensation costs. The Board finds that the evidence in the record at Provider Exhibit 29 shows that the Provider rendered substantial services to patients which were clearly billable under Part B of the Medicare program. Similarly, Provider Exhibit 30 indicates that patient physicals would also constitute a service that is properly reimbursed under Medicare Part B. Thus, the Board finds that the Provider has incurred physician costs that are not reimbursable under Part A of the Medicare program.

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[15] Provider Exhibit 4.
[16] Provider Exhibit 6.

Second, CMS Pub. 15-1 § 2109.3.C states that a claim for Part A or Part B hospital costs must be supported by copies of the contracts between the hospital and the physician(s), a written copy of the allocation agreement supporting the physician's allocation of time, physician payment and time records, and physician billing and charge records. Additionally, the Provider must submit evidence that it explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services.

The Board finds that although these documentation issues were not cited by the Intermediary as the basis for its original adjustments, they were raised by the Intermediary in the Intermediary's position papers dated April 9, 2002. There is no evidence in the record that the Provider has ever responded to the Intermediary's arguments regarding lack of documentation.

The Board has also considered the Provider's arguments relative to the Pelham Bay decision and finds they are without merit. In overturning the Board's decision, CMS stated that there was no regulation presented which would prohibit stand-by costs in the intensive care unit, thus apparently paving the way for the allowance of costs in areas other than a hospital emergency room. However, the decision in Pelham Bay was rendered in 1981 and the regulatory climate has since changed. The Medicare regulation at 42 C.F.R. § 415.55 specifically prohibits reimbursement for stand-by costs outside an emergency room during the period in question. That regulation was promulgated on December 8, 1995, with an effective date of July 1, 1996. Accordingly, the Board concludes that the reasoning the Provider is relying on in Pelham Bay is not applicable to the current case.

The Board agrees that the Provider rendered emergency services and that reimbursement for physician availability services should not be limited to services provided exclusively in an emergency room setting. However, the Board finds that the Provider's failure to meet regulatory and CMS manual documentation requirements for reimbursement of those services leaves no basis for the recognition of Provider's stand-by costs.

DECISION AND ORDER:

The physician stand-by costs were not properly documented. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA

FOR THE BOARD:

DATE: November 21, 2003

Suzanne Cochran
Chairman