PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D12

PROVIDER –
Saginaw General Hospital
Saginaw, Michigan

Provider No. 23-0122

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/United Government Services

DATE OF HEARING -
July 30, 2003

Cost Reporting Period Ended
September 30, 1994

CASE NO. 97-1685

INDEX

ISSUE:

For purposes of allocation of Administrative and General costs, should the Part B physicians' compensation and related fringe benefits be included in total expenses of the private physician practices?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and what proportion of those costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement ("NPR") that sets forth the individual expenses allowed and disallowed by the intermediary. 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835. The cost of physicians private offices that are connected to or affiliated with a hospital are not reimbursed under Medicare Part A. However, the physicians private offices may receive services from the hospital facility or staff. In those instances, Medicare requires that a portion of the hospital's cost be allocated to the physicians private offices in the cost report so that Medicare is not subsidizing the private offices. The amount allocated is derived from statistics developed in the hospital's cost report process. This case involves what expenses are proper to use to develop that pro rata amount for allocation.

Saginaw General Hospital (Provider) is a non-profit, general acute care hospital located in Saginaw, Michigan. The Provider's cost report included hospital based physician salary costs ($1,817,692)[1] and related fringe benefit costs ($265,565)[2] in a non-reimbursable cost center entitled Physician Private Offices.[3] The Provider filed an amended cost report prior to the Intermediary's issuance of the NPR. In that refiling, Provider offset the physicians' costs against the total Physician Private Offices cost center on Worksheet A, line 98 of the Medicare cost report. The Intermediary did not accept the amended cost report. As a result, when the 1994 cost report was settled, the physician's salary and benefit costs were left in the non-reimbursable cost center. The impact on Medicare reimbursement between the cost report originally filed and the amended cost report was approximately $53,000.

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[1] See Provider Supplemental Position Paper Exhibit 1.
[2] Id.
[3] See Intermediary Supplemental Position Paper Exhibit 2.

The Provider is appealing the Intermediary's rejection of its amended cost report and the full allocation of overhead costs to the Physician Private Offices nonreimbursable cost center. The Provider's appeal meets the filing requirements of 42 C.F.R §§405.1835-405.1841. The Provider was represented by Mr. Leo E. Jancila of Strategic Reimbursement, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

JURISDICTIONAL CHALLENGE:

The Intermediary contends that the Board does not have jurisdiction over this issue, citing the HCFA Administrator's vacating of the PRRB's decision in Bon Secours Heartland Home Health Agency v. Blue Cross and Blue Shield Association, PRRB Dec. No. 93-D49, June 23, 1993, Medicare & Medicaid Guide (CCH) ¶41,574 Vac'd. HCFA Adm. Dec, Aug. 23, 1993, CCH ¶ 41,690 (Bon Secours). In Bon Secours, the provider made a request to refile a cost report and the intermediary denied that request. The HCFA Administrator stated that since the cost report was not filed, there was no claim for reimbursement.

The Provider responds that the Board has jurisdiction to hear the factual dispute in this case because, in March of 1996, the Provider refiled its cost report, as evidenced by the Intermediary including a copy of the amended Worksheet A in its Supplemental Position Paper. Since the Provider filed an amended cost report, it filed a claim for reimbursement, the Bon Secours rationale does not apply; and therefore it meets the jurisdictional requirements for appeal to the Board.

The Board finds that the Provider's amended cost report submitted before the Intermediary issued the NPR is tantamount to an objection made by the Provider in its originally filed cost report. Thus, the Provider can make a claim for adjustment of the original report as long as the NPR has not been issued by the Intermediary. The Board, therefore, concludes that it has jurisdiction to hear the disputed claim between the Provider and Intermediary.

SUBSTANTIVE ISSUE:

PROVIDER'S CONTENTIONS:

The Provider contends that the policy of not offsetting physician compensation prior to step-down stems from the position written in various regional CMS letters.[4] The letter states, in part:

> "Since physicians medical and surgical services rendered directly to a patient are paid under Medicare Part B, the Medicare Part A certified provider is not entitled to recover or include costs associated with this activity in its reimbursable costs. Therefore, the Fiscal Intermediary must ensure that any indirect costs incurred by

[4] See, Intermediary Supplemental Position Paper Exhibit 3.

> the Medicare certified provider in its operation of a physician's clinic or other non-patient care related activities are captured during the Medicare Cost Report cost finding process."

The letters further state:

> "In addition, HCFA noted that Fiscal Intermediaries are permitting the elimination, via Worksheet A-8-2 or directly on Worksheet A-8, of nonreimbursable clinic physicians payments included within the physician clinic cost center. These payments were made through either the certified provider's payroll or accounts payable systems. Therefore, the certified provider incurred administrative costs when making these payments. Worksheet A-8-2 is for the comparison of reimbursable physician Part compensation to the "Reasonable Compensation Equivalency" guidelines. Worksheet A-8-2 may not be used to adjust physician payments included in nonreimbursable cost centers. Since the intent is to capture the certified providers support costs incurred due to its operating this nonreimbursable activity, these cost must remain a part of the direct costs of the nonreimbursable activity. This is confirmed in Provider reimbursement Manual ("PRM"), Part I § 2110.4 and Part 2 § 3610.

The Provider believes that the Medicare instruction at HCFA Pub. 15-1 § 2328E (*Amount Applicable to Part B for Hospital Based physicians*), not the letters, governs this issue and argues that Medicare Manual instructions always take precedent over CMS/Intermediary letters. That instruction provides, in part:

> "Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on the Adjustments to Expenses worksheet. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate portion of general service costs."

The Provider interprets this instruction to mean that unless physicians reimburse the hospital for its costs relating to the physician services, the physician fees should be offset on Worksheet A-8.

At issue here is the Intermediary's reversal of the Provider's Worksheet A-8 offsets for payments to hospital-based physicians (HBPs) where the provider bills Medicare Part B on form CMS-1500 (direct billing). The Provider contends that Medicare regulations and cost report instructions state that the cost of physician services for direct patient care, payable from the Medicare Part B Trust Fund (Part B), are not reimbursable under Medicare Part A and should be eliminated from the Medicare cost report on either Worksheet A-8 or Worksheet A-8-2. The regulations do not distinguish between

physicians who work in reimbursable and non-reimbursable cost centers (NRCCs). The Provider also points out that in years prior to the Prospective Payment System (PPS), when a provider compensated a physician for direct patient care services provided in a non-reimbursable off-site clinic, these costs were eliminated from the cost report. The Provider concludes from these instructions and historical treatment that it has always been the intent of the Medicare program to remove all Part B physician compensation from the cost report.

The Provider further argues that another instruction, HCFA Pub. 15-1, Part 2 §3610, describes what is included in a non-reimbursable physician private practice cost center. The list of includable costs identifies all types of private practice costs except physician compensation. The purpose of including these types of costs in a NRCC is for it to receive its pro-rata share of hospital overhead. The Provider argues that the physician fees should not be listed because that would be in direct conflict with HCFA Pub.15-1 § 2328, which specifically states that there may be some physician expense that may be included in hospital costs. That allowability is determined under HCFA Pub. 15-1 § 2182. The cost report instruction implies that the hospital-based physician costs should be included on a reimbursable line in the cost report through a Worksheet A-6 cost reclassification. The physician costs would then be subject to the provisions of HCFA Pub. 15-1 § 2182.

The Provider observes that Medicare interchanges the terms "hospital-based physician" and "provider-based physician" on a regular basis. While these physicians may not be spending time in the main hospital facility, they are working on hospital property. Since the hospital pays the compensation of the physician, whether through the payroll system or the accounts payable system, the revenue generated by the physicians is deemed hospital revenue that is recorded on its general ledger.

The Provider contends that prior Board decisions support its position. It cites Hyde Park Nursing Home (Staatsburg, NY) v. Blue Cross Association/Blue Cross and Blue Shield of Greater New York, PRRB Dec. No. D114, July 2, 1982, Medicare and Medicaid Guide (CCH) ¶ 32095; Franklin Nursing Home (Flushing, NY) v. The Travelers Insurance Company, PRRB Dec. No. 83-D80, May 25, 1983, CCH ¶ 33,021; Concourse Nursing Home (Bronx, New York) v. Travelers Insurance Company, PRRB Decision No. 83-D152, September 27, 1983, CCH ¶ 33,596.

Additionally, the Provider contends that Medicare instructions have taken a strict position regarding allocating overhead costs to Part B physicians. HCFA Pub.15-1 §2122.3 prohibits allocating FICA and other employment related taxes directly to the hospital based physicians professional component.

The Provider disputes the Intermediary's argument that HCFA Pub. 15-1 § 2328 denies offset from non-reimbursable cost centers. It interprets this section as clearly stating that revenue derived from non-allowable activities must not be offset against the non-allowable cost centers. It asserted that the Intermediary takes out of context the wording presented in HCFA Pub. 15-1 § 2328 (E) as the basis for not allowing the offset of Part B

Physician compensation and focuses on the wording that no general service costs would normally apply. The Provider alleges that the Intermediary's statement that the physician clinics, standing alone, would never represent a separate cost center is false. These departments are separately accounted for in the Provider's financial accounting system. Overhead costs are allocated to them on Medicare Worksheet B-1. The Provider's departments must follow the by-laws, policies and procedures of the Provider.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue is one of cost finding which is defined in 42 C.F.R. § 413.24(b). The physicians working in the group practices and their support staff are the primary component of direct costs. The problem is to determine what is the appropriate share of indirect costs associated with the practices. The Provider uses the step-down method described in 42 C.F.R. § 413.24(d)(1). It is undisputed that all costs of the physician group practices are non-allowable. It should also be undisputed that the practice is "revenue producing," and that the physician practices at issue meet the definition of a cost center.

The Intermediary contends that HCFA Pub. 15-1 § 2328 covers the distribution or allocation of general service costs to non-allowable cost centers. The Intermediary argues that the first paragraph applies without exception. It acknowledges that a superficial review of the Manual's language may support the Provider because of the reference to physicians; however, it asserts that a deeper analysis rebuts this argument. The Intermediary observes that of critical note is the statement "no general service costs would normally apply." Id. That qualified observation is correct in the context of how hospitals utilize hospital based physicians. They are engaged to provide the professional service component crucial to the delivery of an ancillary service in which hospital equipment, support staff, and premises are indispensable. Examples are the reading of x-rays, interpreting lab tests, and examining patients in the emergency room. In that context, the statement "no general service cost would normally apply" is correct. The Intermediary argues that the difference in this case is that the physicians are an integral part of a complete business, although non-allowable, owned and operated by the cost report filing entity. General service costs definitely apply and must be allocated. The physician relationships covered in HCFA Pub. 15-1 §2328 E would never, on their own, represent cost centers. Further, if two-thirds of the cost center's expenses are removed, inadequate administrative and general costs will be allocated resulting in cost-shifting in its most basic form.

In response to the Provider's argument that HCFA Pub. 15-2 § 3610 supports its position, the Intermediary again emphasizes that context is critical: the cost report section covers the situation of a hospital as a landlord. It rents space to physicians but does not employ them.

The Intermediary observes that the three cases cited by the Provider present a different factual situation from the instant case. All three appealing providers were skilled nursing facilities (SNFs) located in New York state. All three SNFs employed physicians in the

role of attending physicians. The providers argued and the Board rejected cost report treatment in which the physicians should be considered interns/residents in a non-approved program. The fact pattern is not analogous to the Provider's. Moreover, a case more on point is Chestnut Hill Mental Health Center v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Dec. No. 92-D29, April 10, 1992, CCH ¶ 40,238. That provider owned and operated two psychiatric clinics. The clinics employed psychiatrists and psychologists. Establishing the clinics as non-allowable cost centers was found to be correct.

Finally, the Intermediary observes that the Provider relies on several letters or policy statements of CMS to support the treatment at issue,[5] but it responds that these documents support keeping all physician costs in the non-allowable cost centers. Contrary to the Provider's assertion, the Intermediary's insists that its case is not based solely on those letters. It maintains that the analysis above supports its position without reference to the CMS interpretations. The letters' interpretation is correct because it is based on the Medicare regulations, program instructions, and case precedent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence presented and parties contentions, finds and concludes that the Provider cannot remove physician compensation and related fringe benefits from its established non-reimbursable cost center for the purpose of overhead cost allocation. The Board observes that the Provider's arguments characterize all physicians as hospital-based, but the Board finds this premise to be incorrect. The services rendered by the physicians at the Provider were professional services for patients of the Provider. The Provider was the employer of the physicians in a group practice.

Physicians can offer three types of professional services to providers:

(1) Physician services to the provider as described in 42 C.F.R. § 405.480;
(2) Physician services to patients as described in 42 C.F.R. § 405.550;
(3) Activities of a physician, such as funded research that are not reimbursable under either Part A or Part B of Medicare.

Because the Provider had only physician services related to patients and the Provider billed for physician services under Medicare Part B, the Board finds that 42 C.F.R § 405.550 applies. The reimbursement received by the Provider was on a reasonable charge basis. This methodology was designed to cover physician compensation as well as other overhead costs of physicians in their offices.

[5] See Intermediary Supplemental Exhibit I-3.

Regarding whether to include physician compensation and fringe benefits in the base for allocating administrative and general costs, the Board finds that these costs should remain in the base for allocation. This allows full overhead costs to be allocated to the physician offices and the remaining residual administrative cost to be allocated to the Provider. If the physician compensation costs were removed from the allocation cost base, it would result in additional overhead costs being allocated to the Provider. It would allow a double reimbursement for the Provider's administrative costs, i.e., once through the physicians' charges which include physician office overhead costs and again through the Provider's cost finding. This is obviously not the intent of the Medicare regulations.

Finally, the Board finds that the Provider's reliance on Program instructions is misplaced. The Board finds that HCFA Pub. 15-1 §2328 applies in this case, and that it is consistent with Medicare regulations. Based on the above analysis, the Board concludes that the physician compensation should remain in the non-allowable cost center and should be used in the base for distributing administrative and general expenses to the Provider.

DECISION AND ORDER:

Physician compensation should be: (1) included as part of a non-reimbursable physician offices cost center and (2) part of the allocation base used to distribute A&G expenses.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S
Elaine Crews Powell, C.P.A.

FOR THE BOARD

DATE: February 5, 2004

Suzanne Cochran
Chairman