PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD

2006-D47

PROVIDER -
Rush University Medical Center
Chicago, IL

Provider No.: 14-0119

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal Illinois

DATE OF HEARING -
March 28, 2006

Cost Reporting Periods Ended -
June 30, 1989 and June 30, 1990

CASE NOs.: 03-1587 and 03-1592

INDEX

ISSUE:

Whether the Intermediary should have used the "aggregation methodology" when implementing the updated reasonable compensation equivalent (RCE) limits on compensation paid to Provider's hospital-based physicians.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's determination 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rush University Medical Center (Provider), formerly known as Rush-Presbyterian – St. Luke's Medical Center, is an academic medical center with 824 licensed beds located in Chicago, Illinois. In fiscal years (FY) 1989 and 1990, the Provider claimed costs for approximately 258 hospital-based physicians assigned to 30 departments. The fiscal intermediary, AdminaStar Federal, Inc., made adjustments relating to the reimbursement for the hospital-based physicians in both cost reporting years. The Provider initially brought appeals of its FY 1989 and 1990 cost reports under PRRB Case Nos. 92-1678 and 92-1717, respectively. On July 22, 1997, the Provider and the Intermediary entered into separate but similar Stipulations and Full Administrative Resolutions to resolve all

pending issues in both appeals.[1] One of the issues pending in both appeals depended on the outcome of a case pending in federal court which related to the Provider's FYE 6/30/88 cost report appeal. The 1988 case was decided on August 28, 1997. The Intermediary initially appealed the district court's decision to the Seventh Circuit Court of Appeals, but in January of 1998, voluntarily dismissed its appeal. This dismissal set in motion a series of remands from the district court to the Board and ultimately to the Intermediary. The Intermediary was directed, by the Board per notice dated March 4, 1999, to complete the recalculation of the Provider's reasonable costs for fiscal year 1988 using limits developed through the approved reasonable compensation equivalent updated methodology within 90 days of the date of the order (June 2, 1999).[2]

Once the 1988 case was completely resolved, the 1989 and 1990 cost report apeals could also be revised based upon the outcome of the 1988 case. The Provider submitted workpapers, detailing its calculation of additional reimbursement due, to the Intermediary for both the FY 1989 and FY1990 cost report years to facilitate the implementation of the administrative resolutions. The calculations presented to the Intermediary by the Provider utilized the aggregate methodology in applying the updated RCE limits to allowable physician compensation costs. The Intermediary reviewed the workpapers submitted by the Provider, which utilized the aggregate method, and determined that the only item to be updated was the RCE limits, not the methodology used. The Provider's calculations as submitted were rejected and subsequently revised by the Intermediary to reflect the individual method as reported on the as-filed and final settled cost reports for FYs 1989 and 1990.

The Provider estimates that the Intermediary's refusal to utilize the aggregate methodology resulted in a reduction of Medicare reimbursement of approximately $387,000 for FY 1989 and $507,000 for FY 1990.

The Provider appealed the adjustments to the Board and was determined to have met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by James F. Flynn, Esquire, of Bricker & Eckler LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the issue before the Board pertains to the implementation of an administrative resolution under which the Intermediary agreed to update the reasonable compensation equivalent (RCE) limits for compensation paid to the Provider's hospital-based physicians in FYs 1989 and 1990. As per the settlement agreements signed by both the Intermediary and the Provider, the parties agreed that ". . . the final outcome of Provider's appeal of the Reasonable Compensation Equivalent "RCE" issue for Provider's FYE June 30, 1988, which is now pending in United States District Court for the Northern District of Illinois (Rush Presbyterian-St. Luke's v. Shalala, Case No.

[1] See Exhibit P-5 (for both 03-1587 and 03-1592).

[2] See Intermediary's Exhbit I-3 at 11. Provider Reimbursement Review Board's Notice of Reopening and Order Dated March 4, 1999.

97-C-1726), shall apply equally to the above-referenced appeal except that the annual inflation factor of 4.3% (or whatever other percentage the court or the parties to the litigation agree upon) shall be applied to FYE June 30, 1990[3] for the additional two years beyond that litigated for FYE June 30, 1988."

The Provider asserts that the Provider Reimbursement Manual (PRM) 15-1 §2182.6 allows for two different methodologies for applying the RCE limits. The first and most common methodology is simply applying the RCE limits, by specialty, to the compensation of each hospital-based physician on a physician-by-physician basis (sometimes referred to as the "individual method"). The second methodology, referred to as the "aggregate method," is permitted in larger hospital departments where a hospital has a similar arrangement with numerous physicians in the same specialty to facilitate administration and reduce paperwork. The aggregate methodology allows the Provider to apply the RCE limit to the aggregated total provider services hours and compare the result to the provider services compensation by specialty instead of applying the RCE limit to each physician individually.

The Provider claims that as a part of the process of reopening the 1989 and 1990 cost reports to implement the RCE administrative resolutions, the Provider requested that the Intermediary apply the RCE limits using the aggregate methodology described above. The Provider claims that it meets the requirements of the manual provision to utilize the aggregate method as it is a large hospital with approximately 260 physicians across 30 departments and nine specialties with substantially similar arrangements. In addition, the Provider states that the Intermediary has agreed to allow the Provider to utilize the aggregate methodology to apply the RCE limits for fiscal years 1991 through 1994 that were under appeal and resolved through a mediation process.

The Provider asserts that the timing of its request to use the aggregate methodology should not be used as the basis for the denial since the pertinent manual provision contains no requirement as to the timing of a provider's request, only that a provider has the right to request it. The Provider notes that the Intermediary's decision to deny its request to utilize the aggregate methodology is arbitrary, as the Intermediary cites no authority for its decision in its own workpapers.

The Intermediary asserts that the administrative resolution dated July 22, 1997 allows it to update the RCE limits for inflation only, and does not mention allowing for any changes in methodology used to calculate the RCE limits.[4] The Intermediary asserts that both the 1989 and 1990 cost reports were filed by the Provider using the individual method to calculate allowable physician costs, and that methodology was accepted by the Intermediary during the audit of those cost reports. The Intermediary asserts that the Provider did not appeal the methodology used and accepted by the Intermediary during the initial appeal, but limited the appeal to the RCE limit amounts used in the calculation.

---

[3] See Provider Final Position Paper, Case 03-1587, Exhibit P-5 for identical language referencing the FY June 30, 1989 fiscal year.

[4] See Intermediary's Final Position paper. Exhibit I-2 stipulation and administrative resolution (full).

The Intermediary asserts that PRM 15-1 §2931.2A informs providers that they are bound by their elections submitted on the as filed cost report. Since the method of calculation chosen by the Provider on its filed cost reports for fiscal year 1989 and 1990 was the individual method, the Intermediary asserts that the Provider is bound by its elections and should be held to its initial election under the rules of finality. The Intermediary asserts that the first time the Provider requested the use of the aggregate methodology for both the FY 1989 and 1990 cost reports was when the Provider submitted calculation worksheets on December 14, 2003[5] with the revised RCE calculations. The Intermediary also notes that the 1988 case upon which the administrative resolution was based, also utilized the individual method.

The Intermediary also notes that there is no record of an amended cost report or reopening request being submitted to the Intermediary to consider a change in the methodology from the individual method to the aggregate method. For a request to be valid, it must have been received within 3 years of the initial NPR (dated 9/30/1991).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, evidence and the parties' contentions, the Board finds and concludes as follows:

PRM 15-1 §2182.6 identifies the conditions of payment for costs of physician services to providers. Specifically, PRM 15-1 §2182.6C establishes the RCEs that are compared to the cost paid to the physician to determine the amount that is allowable for Medicare payment. This manual provision identifies two methods available for comparison to the physician cost, the individual method and the aggregate method. PRM 15-1 §2182.6c states in relevant part:

> Generally, it is intended that the RCEs are applied separately for each physician. However, an aggregated application is permitted in larger hospital departments which have similar arrangements with a number of physicians of the same specialty to facilitate administration and reduce paperwork. Under this optional methodology, the provider services hours and compensation of each involved physician is determined individually and then aggregated by specialty to determine total provider services hours and compensation by specialty for all involved physicians. The applicable RCE limit is then applied to the aggregated provider services hours and the result compared to the aggregated provider services compensation to determine allowable provider services compensation costs by specialty.

[5] See Intermediary's Position Paper (03-1587 and 03-1592), page 11.

While the manual provision provides the option to elect the aggregate methodology over the individual methodology, it provides no timeframe in which the election must be made. Although not critical to this decision, PRM 15-1 §2931.2A does prohibit a provider from changing a basis or methodology, once elected: "Once a cost report is filed, the provider is bound by its elections. Except in 2 above, a provider may not file an amended cost report to avail itself of an option it did not originally elect. For example, a provider which has filed a cost report using a more sophisticated method of cost finding cannot file an amended report using the step-down method of cost finding for that period."

The parties agreed in the administrative resolutions signed on June 22, 1997 that the FY 1989 and 1990 cost reports would be revised based upon the outcome of the appeal of the RCE issue for the Provider's FYE June 30, 1988 cost report. Upon review of those documents, as well as the 1988 court decision, the Board found that none of those cited addressed the methodology used to determine the allowable physician compensation.

The Board finds no basis in the court decision, the administrative resolutions or the manual provisions to mandate a change in the methodology elected by the Provider. The Board also finds that as the 1988 case related only to the update of the RCE limits, the Intermediary properly limited its revisions in the 1989 and 1990 cost report reopenings to the update of the RCE limits. Although the Provider argues that the Intermediary has allowed the Provider to utilize the aggregate methodology in years subsequent to the years under appeal, and therefore, should not be opposed to allowing them to use it in the FY 1989 and 1990, the Board does not find that the Intermediary acted arbitrary or capriciously in exercising to the letter the court decision and administrative resolutions as ordered by remand by the Deputy Administrator. The Board also does not find the need to impugn the Intermediary's decision to provide the relief sought by the Provider based on the fact that the Provider did not exercise its full rights to request a reopening or add the methodology issue to its existing appeal within established time frames.

DECISION AND ORDER:

The Intermediary's adjustments utilizing the individual method to determine allowable physician compensation were proper. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: September 7, 2006

Suzanne Cochran
Chairperson