PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D8

PROVIDER -
Rush University Medical Center
Chicago, Illinois

Provider No.: 14-0119

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, Inc.
(formerly AdminaStar Federal, Inc.)

DATE OF HEARING -
February 21, 2007

Fiscal Years Ended -
June 30, 1993 and June 30, 1994

CASE NOs.: 96-0819 and 97-1814

INDEX

ISSUES[1]:

1. Did the Intermediary properly calculate the number of interns and residents for FY 1993 for purposes of the Provider's graduate medical education?

2-A. Were the Intermediary's adjustments to the Provider's bed count as used for purposes of the indirect medical education (IME) calculation proper?

2-B. In calculating the Provider's bed count as used for purposes of the IME calculation, should there have been a reduction for beds used for observation purposes?

2-C. For purposes of the Provider's intern and resident count for IME, was the Intermediary correct in disallowing research rotations for residents participating in an approved medical residency program at the Provider?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395 *et seq*. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[2] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See*, 42 U.S.C. § 1395h and § 1395kk-1, 42 C.F.R. §§ 413.20 and 413.24.

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. *See* 42 C.F.R. § 413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). *See* 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 receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The PPS statute contains a number of provisions that adjust payment based on hospital specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves two of those provisions.

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[1] All other issues raised by the Provider have either been transferred to group appeals or withdrawn.
[2] FIs and MACs are hereinafter referred to as intermediaries.

The provision at 42 U.S.C. § 1395ww(h) prescribes the Medicare payment method to adjust for direct graduate medical education (GME) costs. In brief, the direct GME payment is the product of a hospital's average per resident cost, derived and updated from a 1984 base period, multiplied by the hospital's number of intern and resident FTEs in approved GME programs during the payment year, multiplied by the hospital's Medicare patient load.

The provision at 42 U.S.C. § 1395ww(d)(5)(B) provides that teaching hospitals with residents in approved GME programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. § 412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is calculated using the hospital's ratio of resident FTEs to available beds.

This case involves the count of resident FTEs for both the GME and IME adjustment, and the count of available beds for the IME calculation.

Resident FTEs:

In determining the total number of FTE residents for direct GME reimbursement purposes, 42 C.F.R § 413.86(f)(1) (1993) instructs that subject to weighting factors, the count of FTE residents includes "[r]esidents in an approved program working in all areas of the hospital complex ... "

The regulations governing IME reimbursement were codified at 42 C.F.R. §412.105(g)(1) (1993). The regulations state in pertinent part:

> For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purposes of determining the indirect medical education adjustment is determined as follows:
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> (i) The resident must be enrolled in an approved teaching program . . .
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> (ii) In order to be counted, the resident must be assigned to one of the following areas:
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> (A) The portion of the hospital subject to the prospective payment system.
> (B) The outpatient department of the hospital. . . .

These regulations were retroactively revised by 75 Fed. Reg. 71800, 72147 (Nov. 24, 2010) which states:

> (C) Effective for cost reporting periods beginning on or after January 1, 1983, except for research activities described in paragraph (f)(1)(iii)(B)[3] of

[3] 42 C.F.R §412.105(f)(1)(iii)(B) states: "The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

> this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in § 413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.
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> 42 C.F.R. § 412.105(f)(1)(iii)(C)(2011).

Available Beds:

Medicare regulations at 42 C.F.R. § 412.105(b)(1993) state:

> (b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The Provider Reimbursement Manual (CMS Pub. 15-1) § 2405.3G further explains that, to be considered an available bed, a bed must be permanently maintained for lodging inpatients, available for use, and housed in patient rooms or wards. The term "available beds" is not intended to capture the day-to-day fluctuations in patient rooms being used, but rather, to capture changes in the size of a facility as beds are added to or taken out of service. In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available throughout the entire cost reporting period.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rush University Medical Center (Provider) is a not-for-profit, tertiary care teaching hospital located in Chicago, Illinois. The Provider appealed numerous issues from its fiscal years ended (FYEs) June 30, 1993 and June 30, 1994 NPRs. Prior to the hearing, the Provider and the Intermediary participated in three separate mediation sessions that resulted in partial administrative resolutions that limited the issues presented to the Board. The remaining issues included GME and IME FTEs for FYEs June 30, 1993 and June 30, 1994. Health Care Service Corporation (Intermediary)[4] issued an NPR and adjusted the as-filed GME and IME FTEs and available beds to its audit findings.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1841. The Provider was represented by James F.

[4] Health Care Service Corporation subsequently became known as AdminaStar Federal, Inc. then National Government Services, Inc.

Flynn, Esquire, of Bricker & Eckler LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue #1 –Number of direct GME Pathology residents for FY 1993.

PROVIDER'S CONTENTIONS:

The Provider contends the Intermediary improperly denied time spent by 14 pathology residents on elective rotations within their approved residency training program when calculating GME FTEs.[5] The Provider states it is uncontested that in FY 1993 it operated an "approved" pathology residency program as defined by Medicare regulations. The Provider asserts all of the pathology residents' elective rotations remaining in dispute were performed at the Provider and should therefore be included in the Provider's FTE count. The rotation schedules supplied show the pathology rotations in dispute and do not indicate they were at another provider's location.[6] The Provider takes the stand that if its rotation schedule did not identify the pathology rotation as occurring at another provider, the rotation must have been performed at the Provider. The Provider's Pathology Department Chairman supplied a "letter [that] serves as an explanation of 'elective' rotations for residents in the Department of Pathology."[7] The Provider asserts this letter verifies that all the elective rotations occurred at the Provider.

INTERMEDIARY'S CONTENTONS:

The Intermediary contends the letters from the Pathology Department Chairman give a "vague, ten-year, after-the-fact recollection" that is "simply not good enough" documentation to support the Provider's claim.[8] The Intermediary believes the regulations and case law place the burden of proof to supply sufficient auditable documentation on the Provider. The Intermediary points to inconsistencies/errors in the Pathology Department Chairman's letters as a basis for determining them to be inadequate. The Intermediary offered, for example, the Pathology Department Chairman's letter dated February 25, 2003 that stated he "believed that all offsite rotations were noted on the schedule.[9]" That statement was proven wrong in that the "Elect/Ped" rotation not labeled as offsite was conceded to have occurred at an unrelated children's hospital.[10] Finally, the Intermediary was concerned that even though the Directory of Graduate Medical Education Programs for 1992-1993 indicated Christ Hospital was one of the institutions where residents would spend a significant portion of their time, not one resident on the schedule showed any rotation to Christ Hospital, nor were there any rotations indicating a residents involvement in research as a part of his/her residency training.[11]

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[5] Provider's Post Hearing Brief at 5-7 (1993).
[6] *See* 1993 rotations schedules at Intermediary Exhibit I-22 and Provider Exhibit P-17 (1993).
[7] *See* Intermediary Exhibit I-22 at 6/7(1993).
[8] *See* Transcript (Tr.) at 48.
[9] *See* February 25, 2003 letter. Intermediary Exhibit I-22 at 6-7 (1993).
[10] Tr. at 76. Also I-22 at 4-7 (1993).
[11] *See* Intermediary's Final Position Paper at 21-22 (1993). *See also* Intermediary Exhibit I-23 at 13/13 (1993).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds the Provider failed to meet the burden of proof needed to overturn the Intermediary's audit adjustment.

The Board concludes that the Provider failed to maintain adequate and verifiable documentation to support its claim that the elective resident rotations in controversy were performed at the Provider's location. Under the regulations at 42 C.F.R. §§ 413.20 and 413.24, the Provider is required to maintain sufficient financial records and adequate data to assure the proper determination of costs under the Medicare program. The recordkeeping requirement includes the concept that data be accurate, maintained in sufficient detail to accomplish its intended purpose, and must be capable of verification by qualified auditors. The Provider did not meet its obligation under these regulations.

The Board finds both the original and revised rotation schedules failed to identify where rotations took place.[12] A rotation schedule is prepared at the beginning of the program year to identify the area in which each resident will work at various times throughout the academic year. It is not uncommon for changes to occur during the year and in fact, changes have been indicated in this case.[13] The February 25, 2003 letter from the Department of Pathology Chair asserted that where the rotation schedule did not identify the rotation as occurring at another hospital, the rotation occurred at the Provider.[14] During the course of this appeal the Provider agreed that this assumption was not valid and that certain elective rotations took place at another hospital even though the rotation schedule did not identify them as such.[15] The Board also finds the February 25, 2003 letter from the Department of Pathology Chair was inadequate evidence as it was not contemporaneous, the letter was unsworn, contained discrepancies with other evidence, was incomplete, and did not identify all the contested residents who had elective rotations. Therefore, the Board concludes that the Provider failed to maintain adequate and verifiable documentation to support its claim that the elective resident rotations in controversy were performed at the Provider as required under the regulations at 42 C.F.R. §§ 412.105(g)(1), 413.86(f)(1), 413.20 and 413.24 (1993).

Issue #2-A. Provider's bed count as used for purposes of the IME calculation.

PROVIDER'S CONTENTIONS:

The Provider contends that the available bed count is overstated by the beds that were taken out of service during the fiscal year. The Provider argues it is clear that the beds located in inpatient units where major construction occurred were not continuously available throughout the cost reporting period. For the other contested beds the Provider asserts testimony and other evidence shows 72 hours was the minimum time it would take to place the beds back in service.[16] The reasons given for the extended time to place beds back in service included: nursing personnel

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[12] *See* Intermediary Exhibit I-22 at 1/7 and 2/7 (1993).
[13] *Id.*
[14] *Id.* at 6/7.
[15] Tr. at 75-76.
[16] Tr. at 176-177.

and the ability to staff the bed, billing and chargemaster personnel and the ability to bill for the bed, facilities personnel and the ability to connect oxygen and secure beds from an outside leasing company.

The Provider argues the beds at issue were not available "within a short period of time," the unsupported standard argued by the Intermediary, nor were the beds "permanently maintained for lodging inpatients" as explained in the CMS Pub.15-1 § 2405.3.G. The Provider maintains its calculation "capture[s] changes in the size of the facility as beds are added to or taken out of service." *Id., See also,* CMS Pub. 15-2 § 1506. The Provider also argues the Intermediary has not provided a documented "rule of thumb" on defining "a short period of time" as applied to an available bed as required by the regulation.[17] Also, the Provider notes the Intermediary auditors used 72 hours as a standard in other fiscal years.[18] The Provider believes it has shown beds that are taken out of service are not available within 72 hours.

Finally, the Provider argues that the facts in this case are distinguishable from the two cases cited by the Intermediary. In *Altoona Hospital vs. Thompson*, 131 Fed.Appx. 355, (3rd Cir. 2005) (*Altoona)*, the hospital "has not disputed that it maintained [the beds at issue] for immediate use by inpatients." The Provider argues the facts in this case show it could not make the beds at issue available on an "as needed" basis. In *United Hospitals Medical Center vs. Blue Cross/Blue Shield Ass'n./Blue Cross Blue Shield of New Jersey,* PRRB Hearing Dec. No. 2000-D23 (Mar. 2, 2000)[19] (*United*), the Board found that due to a lack of documentation it could not determine if the beds in question were permanently or only temporarily closed. In this case the Provider believes it has supplied extensive and detailed workpapers with supporting documentation. The Provider asserts it is equally important that the Intermediary has not produced conflicting proof.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the Provider has not shown that the beds in controversy were taken out of service and made unavailable to the extent that they could not be converted back to patient care use within a short period of time should the need arise. Instead, the Intermediary asserts the hospital has excess capacity, and is administratively managing that capacity, not clearly and irrevocably converting beds/areas to a non-inpatient use. The Intermediary gives an example of an area that was closed for "a short two-week closure"[20] and argues that this type of short-term fluctuation doesn't meet the standard established for when a bed is considered "unavailable."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the majority of the beds in controversy were unavailable during the periods in question.

The Board finds the pertinent regulations provide IME bed count rules at 42 C.F.R.

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[17] Tr. at 245-247 and 346-348.
[18] *See* Provider's Final Position Paper Exhibit P-35 (1993).
[19] Intermediary Exhibit I-17 (1994).
[20] Tr. at 44-45.

§412.105(b)(1993) which states:

> (b) *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

The CMS Pub.15-1 § 2405.3G further explains:

> G. Bed Size.—A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, postanesthesia or postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.
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> 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.
>
> In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. The hospital bears the burden of proof to exclude beds from the count.

The Board finds the majority of beds in question were taken out of service making them unavailable for inpatients if they were needed. The Provider has demonstrated that it would take at least 72 hours to make the out of service beds available;[21] therefore, the Board finds the beds were not permanently maintained for inpatients. Based on testimony regarding the process of

[21] Tr. at 176-177, 187-189.

taking beds out of service and bringing them back in service,[22] and two types of contemporaneous evidence[23] (memoranda related to closures, and Room and Bed Master Price Index reports), the Board finds the evidence credible that the beds were removed and unavailable for use by inpatients. The Board also finds that the memoranda of closure dates and the Room and Bed Master Price Index reports documented the dates that changes in available beds occurred and quantified the number of beds available. The Board reviewed the Provider's bed counts and dates in service found on the "Summary of IME Bed Count Dispute" contained in the Provider's Hearing Exhibit Binder at Exhibit P-16 (1993) and at Exhibit P-11 (1994). The Board verified the bed counts and dates in service on these schedules by cross-referencing to the contemporaneous memoranda related to closures, and Room and Bed Master Price Index reports. The Board found the bed counts and dates in service matched except as follows:

FYE 1993[24]

The Board finds unit 3 Pavilion (03PV) starting count should be 22 available beds as documented on pages 7-8 of the Room and Bed Master Price Index report found at Provider Exhibit P-31(1993) versus the 20 beds on the Provider's Summary of IME Bed Count Dispute, FYE 1993. Based on the Board's review, the first time that contemporaneous documentation supports the 20 available beds is on the 03/18/93 Room and Bed Master Price Index report found at Provider Exhibit P-16 page 0099 (1993). Therefore, the Board finds unit 3 Pavilion has the following weighted average available bed count:

Bed Count	Dates in Service	Days	Weighted Bed Count
22	6/30/92-3/18/93	261	15.73
20	3/18/93-6/30/93	104	5.70
	Total	365	21.43

FYE 1994[25]

The Board finds unit 5 Kellogg (05EP) starting count should be 34 available beds as this was the ending count in the previous year and there is no document indicating it was reduced prior to the memorandum dated February 2, 1994[26] that shows all but 10 beds were being taken out of service as of February 4, 1994[27]. The Room and Bed change report dated 03/01/94 found at Provider's Hearing Exhibit Binder Exhibit P-11 at 0050-0052 (1994) shows all beds being taken out of service ("o" placed in last column). Therefore, the Board finds unit 5 Kellogg has the following weighted average available bed count:

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[22] *Id.*

[23] Provider's Final Position Paper Exhibits P-16 (1993) and P-11(1994).

[24] The Board notes the Intermediary has conceded that inpatient unit 9 Kellogg was unavailable due to construction after December 12, 1992 overstating the available bed count by 25.21 for the fiscal year 1993. Tr. at 240-241.

[25] Tr. at 225-228.

[26] Provider's Hearing Exhibit Binder Exhibit P-11 at 0049 (1994).

[27] Although, the Provider's Post Hearing Brief at FN 2 shows the reduction to 10 beds occurring on February 2, 2004, the contemporaneous memorandum dated February 2, 1994 lists the effective date of the change as February 4, 1994. *See* Provider's Hearing Exhibit Binder Exhibit P-11 at 0049 (1994). Therefore the later date was used in the Board finding.

Bed Count	Dates in Service	Days	Weighted Bed Count
34	7/01/93-2/04/94	218	20.40
10	2/04/94-3/01/94	25	2.07
0	3/01/94-6/30/94	121	0.00
	Total	364	22.47

The Board finds the Provider has met its burden of proof through the preponderance of evidence and that subject to the corrections noted above, the bed counts and dates in service are correct on its "Summary of IME Bed Count Dispute" at Provider's Hearing Exhibit Binder at Exhibit P-16 page 0085 (1993) and at Exhibit P-11 page 0042 (1994).

Finally, the Board finds the *Altoona* and *United* decisions have different facts and are not relevant to these cases. The Board finds the Provider did not maintain the beds at issue "for immediate use by inpatients" contrary to the situation in *Altoona.* The Board further finds the Provider supplied detailed workpapers with supporting documentation, contrary to what occurred in *United.*

Issue #2-B. Provider's IME bed count: Observation beds.

PROVIDER'S CONTENTIONS:

The Provider contends the IME bed count is overstated because it does not properly reflect the days that beds were not available for inpatients as a result of their use for a non-PPS service: outpatient observation bed services. The Provider asserts it claimed the observation bed days on its cost report.[28] The Provider also asserts the summary supplied of hours charged for observation services by unit is adequate documentation of the days.[29] The observation days claimed on Worksheet S-3, Part I were not adjusted when the Intermediary originally audited the cost report nor, the Provider contends, did the Intermediary make the manual adjustment needed to reflect the observation bed days reduction at the time of the audit, even though the Intermediary testifies, "[w]e do not have a problem with, that observation bed days should be excluded from the IME calculation."[30]

The Provider self-disclosed erroneous billings for Medicare outpatient observation services rendered on or after July 1, 1993.[31] The Provider believes this is the only reason the Intermediary has not agreed to reduce available bed days by observation days for these two cases. The Provider asserts the billings in question were for patients occupying inpatient beds while recovering from an outpatient surgical or cardiac procedure because of a "lack of room in the recovery room."[32] The Provider argues beds occupied for recovery room purposes and/or for

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[28] Provider Exhibit P-29 (1993), Provider Exhibit P-25 (1994).
[29] *Id.*
[30] Tr. at 407.
[31] *See* Self disclosure letter at Provider Exhibit P-32 (1994). The Provider acknowledges that the overpayment "problem went at least back to February 1997 when we converted to a new billing system. . . Cases prior to February 1, 1997 were billed on the medical center's old system. . . Diagnostic data is not available in the old system."
[32] *Id.*

observation bed purposes are not available for inpatient use. Therefore, they should be subtracted from otherwise available inpatient bed days. The Provider argues that nowhere in the regulation or the CMS Pub. is the determination of the number of beds linked to whether the services rendered in them—whether they be observation bed services or whatever other use—be billable and billed correctly to Medicare. Finally, the Provider argues because the self-disclosed error affected the period beginning July 1, 1993, there is no effect on its fiscal year ended June 30, 1993 observation days.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the self-disclosure of the billing issue raises questions about the core reliability of the observation information that the Provider cannot answer.[33] The Intermediary believes the improperly billed outpatient observation service days must be removed from the total observation bed days claimed prior to determining the observation bed days to be removed from available bed days.[34]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes that the total hours that outpatient observation patients utilize inpatient beds should be removed from the available bed days calculation even though the services rendered to patients in those beds may not have qualified as observation services for billing purposes.

The Board finds the parties in agreement that observation bed days should be excluded from the IME available bed days calculation.[35] CMS discussed the exclusion of observation beds at 68 Fed. Reg. 45346, 45418-45419 (August 1, 2003) stating:

> Observation services are those services furnished by a hospital on the hospital's premises that include use of a bed and periodic monitoring by a hospital's nursing or other staff in order to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. When a hospital places a patient under observation but has not formally admitted him or her as an inpatient, the patient initially is treated as an outpatient. Consequently, the observation bed days are not recognized under the IPPS as part of the inpatient operating costs of the hospital.
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> Observation services may be provided in a distinct observation bed area, but they may also be provided in a routine inpatient care unit or ward. In either case, our policy is the bed days attributable to beds used for observation services are excluded from the counts of available bed days and patient days at §§ 412.105(b) and 412.106(a)(1)(ii). This policy was clarified in a

[33] Tr. at 45-47.
[34] Tr. at 383-384. The Intermediary's witness explained that the observation days for FY1994 would have been reduced from 2,152 to 19 days had the self-disclosed information been adjusted on the cost report.
[35] Tr. at 407.

> memorandum that was sent to all CMS Regional Offices (for distribution to fiscal intermediaries) dated February 27, 1997, which stated that if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the days that those beds are used for observation services should be excluded from the available bed day count (even if the patient is ultimately admitted as an acute inpatient).
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> * * * * *
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> . . . The policies to exclude observation bed days and swing-bed days as described above stem from the fact that these days are not payable under the IPPS.

The Board finds that for the bed days in controversy, the Provider was placing outpatient observation patients in hospital inpatient beds. These observation services are excluded from payment under the IPPS system. Therefore, the Board finds the hours/days that these patients occupied inpatient beds should be removed from the available bed days related to IPPS services.[36] For 1994, the Board finds the self-disallowance for erroneous observation billings does not alter the fact the beds were occupied by outpatient observation patients and therefore unavailable for lodging inpatients. Even if the patients were recovery room patients they would be occupying and making unavailable inpatient beds. The Board also agrees with the Provider the self-disclosed error does not affect the period beginning prior to July 1, 1993.[37] Finally, the Board finds the supporting documentation for the observation hours based on charges adequate to support the observation days removed.[38]

Issue # 2-C Exclusion of time spent by residents in research when counting IME FTEs.

PARTIES' STIPULATIONS:

The Provider and Intermediary requested the IME research issue be heard on-the-record and stipulated to the following pertinent facts. The two years of stipulations have been combined below[39]:

- Attached as Exhibit A to this stipulation is an agreed-upon listing of the interns and residents who had research rotations disallowed by the Intermediary for the Provider's fiscal year[s] ended June 30, 1993 [and] June 30, 1994 (FY 1993 and FY 1994).

- The programs in which the interns and residents listed in Exhibit A participated in FY[s] 1993 [and] 1994 (identified under the column heading "Approved Programs") all met the definition of an "approved medical residency program" in FY 1993 [and] 1994, as that term was

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[36] The Board is applying the 2003 Federal Register to FYs 1993 and 1994 because the parties have agreed to its principle of excluding observation days from bed days available.
[37] *See* Self disclosure letter at Provider Exhibit P-32 (1994).
[38] Provider Exhibit P-29 (1993), Provider Exhibit P-25 (1994). See Provider's Hearing Exhibit Binder(s)
[39] Stipulations of fact (Research FTEs) Provider Exhibit P-45 (1993), Provider Exhibit P-40 (1994).

defined under 42 C.F.R. § 413.86 (1992 [and] 1993), the regulation in effect and applicable in FY[s] 1993 [and] 1994.

- For purposes of being accredited or otherwise satisfying the requirements for an "approved program," each of the programs listed on Exhibit A in FY[s] 1993 [and] 1994 included the research rotation at issue. The research rotation was either a required component of the approved program or a permitted elective of such program.

- While participating in the research rotations described on Exhibit A, each of the interns and residents listed on Exhibit A were located either in the portion of the Provider's facility that is subject to the prospective payment system or in an outpatient department of the Provider. The parties agreed to the basic contents of letters which confirm this statement of fact. The Provider secured such letters and they are hereby submitted as Exhibit B to this Stipulation.

- In disallowing the interns and residents at issue, the sole reason cited and relied upon by the Intermediary is the fact that they were participating in a research activity.

- The regulation which is at issue in considering this issue is found at 42 C.F.R. §412.105. That regulation was amended once during Provider's FY 1993, but the amendment did not affect sub-paragraph (g) and once during Provider's FY 1994, and the amendment did include changes to sub-paragraph (g) [see sub-paragraphs (g)(1)(ii) and (iii)], which is the sub-section of that regulation at issue. Attached as Exhibit C is a copy of the applicable regulation in effect. . .

- The Provider and the Intermediary stipulated and agreed upon those exhibits introduced into the evidentiary record by each such party which pertain specifically to the issue of research rotations. Attached as Exhibit D is an index listing the Provider's exhibits and attached as Exhibit E is an index listing the Intermediary's exhibits.

PROVIDER'S CONTENTIONS:

The Provider contends the plain language of the IME regulation at 42 C.F.R. § 412.105 controls and is not ambiguous. The regulation requires that to be included in the IME FTE count, a resident must be (1) enrolled in an approved teaching program, and (2) assigned to work in the portion of the provider subject to the prospective payment system or an outpatient department of the provider. The Provider believes these two elements of the IME regulation were met per the stipulated facts. The Provider finds it significant that the approved teaching programs require that the interns and residents engage in research.[40]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. §§ 413.5 and 413.90 specifically preclude any payment of Medicare funds for research that is not directly related to treating particular patients. As such, any time spent by residents performing research activities that are not directly related to

[40] See Stipulated paragraph 2 at Provider Exhibit P-45 (1993) and P-40 (1994).

patient care, that is, the diagnosis or treatment of particular patients, is excluded from the resident count. The Intermediary contends that CMS guidance contained in CMS Pub. 15-1 §2405.3 also reflects that a resident must not be included in the IME count if "[t]he individual is engaged exclusively in research."[41] The Intermediary argues that CMS clarified the manual section in August 2001, in its response to comments regarding IME payment issues.[42] The Intermediary contends that the Provider has failed to show that any of the disallowed resident time spent in research was directly related to the diagnosis or treatment of specific patients; thus, the FTE time spent in research may not be included in the IME FTE count.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and stipulations and the evidence contained in the record, the Board finds and concludes that the Intermediary's removal of IME FTEs related to a research rotation was proper.

The Board finds Congress revised the rules for calculating hospitals' FTE counts in the Patient Protection and Affordable Care Act (PPACA), Pub.L. No. 111-148, § 5505, 124 Stat. 119, 660-61 (2010). The Board agrees with the Sixth Circuit Court's analysis, which states:

> For the years between 1983 and 2001, the years at issue, the Act says that the Secretary must include in the hospital's indirect FTE counts
>
> > [A]ll the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital.
>
> PPACA § 5505(b); *see id.* § 5505(c) (providing that this provision is effective for "cost reporting periods beginning on or after January 1, 1983" through those beginning on September 30, 2001). Exercising her authority to define "such time and activities," the Secretary promulgated a regulation specifying that eligible non-patient care activities do not include the time residents spend conducting pure research. Payments to Hospitals for Graduate Medical Education Costs, 75 Fed. Reg. 71,800, 72,261 (Nov. 24, 2010) (to be codified at 42 C.F.R. § 412.105 (f)(1)(iii)(C)).
>
> *See,* Henry Ford Health System v. Department of Health and Human Services, 654 F.3d 660 (6th Cir. 2011).

The newly codified regulations state:

> (C) Effective for cost reporting periods beginning on or after January 1,

[41] Intermediary's Final Position Paper at p. 27 and Exhibit I-20, page 6 of 11(1993).
[42] Intermediary's Final Position Paper at 28 (1993).

> 1983, except for research activities described in paragraph (f)(1)(iii)(B) of this section, the time a resident is training in an approved medical residency program in a hospital setting, as described in paragraphs (f)(1)(ii)(A) through (f)(1)(ii)(D) of this section, must be spent in either patient care activities, as defined in § 413.75(b) of this subchapter, or in nonpatient care activities, such as didactic conferences and seminars, to be counted. This provision may not be applied in a manner that would require the reopening of settled cost reports, except those cost reports on which, as of March 23, 2010, there is a jurisdictionally proper appeal pending on direct GME or IME payments.
>
> 42 C.F.R. § 412.105(f)(1)(iii)(C)(2011).

The referenced "paragraph (f)(1)(iii)(B)" states: "The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable." Based upon this regulation the Board finds no evidence was presented to show the research time in controversy to be related to the treatment or diagnosis of particular patients, and therefore, the Board concludes the research time is not countable. The Intermediary's position is based upon the fact that the research rotations in controversy have not been shown to be directly related to treating particular patients. The Provider chose not to rebut that position and relied solely on its reading of the regulation in existence at the time. The Board finds the Provider has not documented the research rotations as being related to treating particular patients.

DECISION AND ORDER:

Issue #1 –Number of direct GME Pathology residents for FY 1993.

The Intermediary's adjustment excluding FTEs attributable to time spent by pathology residents on elective rotations was proper. The Intermediary's adjustment is affirmed.

Issue #2-A. Provider's bed count as used for purposes of the IME calculation.

The Intermediary's adjustments increasing available beds by not recognizing beds taken out of service by the Provider are modified. The Intermediary should recalculate the IME adjustment by reducing available beds for beds taken out of service as stated in the Board decision.

Issue #2-B. Provider's IME bed count: Observation beds.

Available bed days should be decreased to exclude observation/recovery bed days. The Intermediary's adjustments are reversed.

Issue # 2-C Exclusion of time spent by residents in research when counting IME FTEs.

The Provider's IME FTE resident count should not include the time spent by residents in research rotations. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Yvette C. Hayes
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: FEB 08 2012