# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D9

**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 -**
May 10, 2007

Fiscal Year Ended - June 30, 1996

**CASE NO.:** 00-2351

**INDEX**

ISSUES[1]:

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

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

5-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). One of those provisions creates payment for indirect medical education.

The provision at 42 U.S.C. § 1395ww(d)(5)(B) provides that teaching hospitals that have 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.

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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 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 and the count of available beds for the IME calculation.

IME Resident FTEs:

The regulations governing the IME adjustment were codified at 42 C.F.R. §412.105(g)(1) (1996). 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 purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program . . .
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (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 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).

IME Available Beds:

Medicare regulation 42 C.F.R. § 412.105(b)(1996) states:

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[3] 42 C.F.R §412.105(f)(1)(iii)(B) (2011) 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."

> (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 or bassinets in the healthy newborn nursery, custodial care beds, or beds in 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 beds, 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 year ended (FYE) June 30, 1996 NPR. Prior to the hearing, the Provider and the Intermediary participated in mediation sessions that resulted in partial administrative resolutions that limited the issues presented to the Board. The remaining issues included IME FTEs and available beds for FYE June 30, 1996. AdminaStar Federal, Inc. (Intermediary)[4] issued an NPR and adjusted the as-filed 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. Flynn, Esquire, of Bricker & Eckler LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

Issue #5-A. Provider's bed count as used for purposes of the IME calculation.

PROVIDER'S CONTENTIONS:

The Provider believes the controversy focuses on two issues: when were inpatient units available in relation to the beginning or end of construction, and how many beds were available when they were open. The Provider offers proof in the form of internal memos, Patient Care Information System (PCIS) billing change reports, Room and Bed Master Price Index reports, Intermediary workpapers, testimony and affidavits. The Provider's testimony and affidavit describe units being vacated, beds and supplies removed, oxygen shut off, and furniture and equipment removed, concluding "it would take many days for a unit that is vacated, empty and stripped down as described above before it could be made available again for patient care."[5]

The Provider argues the beds at issue were not available "within a short period of time," the

[4] AdminaStar Federal, Inc. subsequently became known as National Government Services, Inc.
[5] Provider's Exhibit P-43 at paragraph 5d.

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 adequately defined "a short period of time" as applied to an available bed as required by the regulation. The Provider notes the Intermediary auditors have used 72 hours as a standard in other fiscal years.[6] 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 three 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) (*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. In *Martin Luther King, Jr./Drew Medical Center v. Blue Cross Blue Shield Association/United Government Services*, PRRB Hearing Dec. No. 2007-D16 (Jan. 26, 2007) (*Martin Luther King*) the Board relied heavily upon a Blue Cross Blue Shield "Administrative Bulletin" that exists nowhere in the record in this case nor is it available to the Provider. Therefore *Martin Luther King* provides no guidance to the case at hand.

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts the hospital has excess capacity, and is merely managing the excess, as opposed to taking beds out of service. The Intermediary believes that when counting beds the number of licensed beds is a fair starting point. The Intermediary argues that in a practical sense what takes a bed out of service is an irrevocable conversion to an alternate use that precludes restoring the space to the capacity to deliver inpatient care in any type of short-term turnaround. The Intermediary believes this is the principle recognized in the *Martin Luther King* decision. The Intermediary contends a debate that focuses on whether a bed can be restored to use within 72 hours, rather than 48 hours, indicates a closure far from permanent. The Intermediary also asserts licensed beds removed from the billing system are still "available."

The Intermediary concedes inpatient units under extensive renovation can be unavailable for lodging patients. The Intermediary asserts the construction was inextricably related to the presence of excess capacity. Excess capacity gave the Provider the ability to close down areas for renovation while still having adequate inpatient care unit space at all times. Therefore, it could time the completion of one unit to coincide with starting work on another unit. The Intermediary argues there is no direct correlation between the areas taken out of service because of remodeling and the actual unavailability of beds within a unit for patient care. The Intermediary further argues that except for the time the unit was actually "hardhatted" for active construction, the area

[6] Provider's Exhibit P-34, Transcript (Tr.) 81-82.

maintained its available bed capacity. The Intermediary also disputes the actual capacity of units when they were open.

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 beds on floors closed for construction were unavailable.

The Board finds the pertinent regulations provide IME bed count rules at 42 C.F.R. § 412.105(b)(1996) 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 or bassinets in the healthy newborn nursery, custodial care beds, or beds in 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.
>
> 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 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,[7] therefore, the Board finds the beds were not permanently maintained for inpatients. Based on testimony regarding the process of taking beds out of service and bringing them back in service[8], and contemporaneous evidence[9] (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 for inpatients. The Board also finds that the memoranda of closure dates and the Room and Bed Master Price Index reports document 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 Final Position Paper at Exhibit P-9. 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 for the starting bed count for unit 10 Kellogg which should be 36 not 26.[10] Therefore, the Board finds unit 10 Kellogg has the following weighted average available bed count:

| Bed Count | Dates in Service | Days | Weighted Bed Count |
|---|---|---|---|
| 36 | 7/01/95-9/01/95 | 62 | 6.12 |
| 0 | 9/01/95-6/30/96 | 303 | 0.00 |
| | Total | 365 | 6.12 |

The Board finds the Provider has met its burden of proof through the preponderance of evidence and that subject to the correction noted above, the bed counts and dates in service are correct on its "Summary of IME Bed Count Dispute" at Provider's Final Position Paper at Exhibit P-9.

Finally, the Board finds the *Altoona*, *United* and *Martin Luther King* decisions have different facts and are not relevant to this instant case. The Board finds the Provider did not maintain the beds at issue "for immediate use by inpatients" contrary to *Altoona.* The Board further finds the Provider supplied detailed workpapers with supporting documentation, contrary to what occurred in *United.* In *Martin Luther King* the provider indicated its beds could be placed in service if required with a short period of time.

Issue #5-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

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[7] *See* Tr. at 81-83. *See also*, Provider's Exhibit P-34 for relevant Intermediary FYE 2000 work papers.
[8] *Id.*
[9] Provider's Final Position Paper Exhibit P-9.
[10] *Id.* at 96-3 2/2 and Tr. at 49-50.

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.[11] The Provider also asserts the summary furnished of hours charged for observation services by unit is adequate documentation of the days.[12] 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 does not dispute that observation bed days should be used to reduce the IME bed count.[13]

The Provider self-disclosed erroneous billings for Medicare outpatient observation services rendered on or after July 1, 1993.[14] The Provider asserts the Intermediary will only reduce available bed days for the 53 observation bed days for patients who did not have the self-disclosed billing error.[15] 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." The Provider argues beds occupied for recovery room purposes and/or for 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 PRM 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.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends the actual observation time that was successfully billed (53 days =1,279 hours/24 hours per day) was the best measure of observation bed time.[16] The Intermediary believes the observation bed days as revised through the reopening are the observation bed days to be removed from available bed days.[17]

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 when 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.

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[11] Provider's Exhibit P-31.
[12] *Id.*
[13] Tr. at 235 and 268.
[14] *See* Self disclosure letter at Provider's Exhibit P-32.
[15] The Intermediary reopened the Provider's cost report and reduced the reported observation bed days of 3,026 to 53 based on the Provider's self-disclosure of the billing error. *See* Intermediary's Exhibit I-58 for revised Worksheet S-3 and Tr. at 263. The Intermediary's witness then testified the 53 revised observation bed days are "utilized on the cost report to calculate reimbursement." Tr. at 265-267. The Provider also contests the accuracy of the 53 revised observation bed days. *See* Provider's Post Hearing Brief at 40-42 referring to Provider's Exhibit P-8.
[16] Provider's exhibit P-8 last three pages.
[17] Tr. at 265-267.

The Board finds the parties in agreement that observation bed days should be excluded from the IME available bed days calculation.[18] 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.
>
> 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 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).
>
> * * * * *
>
> . . . 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.[19] 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. Finally, the Board finds the supporting documentation for the observation hours based on charges adequate to support the observation days removed.[20]

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[18] Tr. at 268.
[19] The Board is applying the 2003 Federal Register because the parties have agreed to its principle of excluding observation days from bed days available.
[20] Provider's Exhibit P-31.

Issue # 5-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:

1. The issue to be decided by the Board is as follows: For purposes of the Provider's intern and resident count for indirect medical education, was the Intermediary correct in disallowing research rotations for residents participating in an approved medical residency program at the Provider?

2. Attached as Exhibit A to this Stipulation is an agreed-upon listing of interns and residents who had research rotations disallowed by the Intermediary for the Provider's fiscal year ended June 30, 1996 ("FY" 1996).

3. The programs in which the interns and residents listed in Exhibit A participated in FY 1996 (identified under the column heading "Approved Programs") all met the definition of an "approved medical residency program" in FY 1996, as that term was defined under 42 C.F.R. § 413.86 (1995), the regulation in effect and applicable in FY 1996.

4. For purposes of being accredited or otherwise satisfying the requirements for an "approved program," each of the programs listed on Exhibit A in FY 1996 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.

5. 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 have 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.

6. 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.

7. 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 1996, but the amendment did not substantively affect sub-paragraph (g), which is the sub-section of that regulation at issue. Attached as Exhibit C is a copy of the regulation as in effect from July 1, 1995 through September 30, 1995 and a copy of the regulation as in effect from October 1, 1995 through June 30, 1996.

8. The Provider and the Intermediary have stipulated and agreed upon those exhibits introduced into the evidentiary record by each such party which pertain 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.

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 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."[21] The Intermediary argues that CMS clarified the manual section in August 2001, in its response to comments regarding IME payment issues.[22] 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
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> > [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

[21] Intermediary's Final Position Paper Exhibit I-10, page 5 of 10.
[22] Intermediary's Final Position Paper at 20.

> such time and activities are defined by the Secretary, that occurs in the hospital.
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> 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)).
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> *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, 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 a particular patient, 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 #5-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 were improper. The Intermediary should recalculate the IME adjustment by reducing available beds for beds taken out of service as stated in the Board decision.

Issue #5-B. Provider's IME bed count: Observation beds.

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

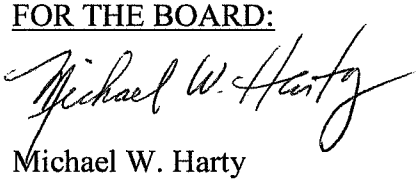
Issue # 5-C Exclusion of time spent by residents in research when counting IME FTEs.

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