PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D35

PROVIDER –
Cleveland Clinic Hospital
Cleveland, OH

Provider No.: 36-0180

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
CGS Administrators, LLC

DATE OF HEARING -
November 16, 2012

Cost Reporting Period Ended -
December 31, 2002

CASE NO.: 06-0328

INDEX

ISSUE:

Whether the contractor's decision to exclude certain physician Medicare Part A administrative costs under time study codes L and O from the Provider's fiscal year (FY) 2002 wage index data in calculating the FY 2006 wage index should be reversed?[1]

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 under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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).[2] FIs and MACs determine payment amounts due the providers under Medicare law, regulations, and under interpretive guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[4] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues a Notice of Program Reimbursement (NPR).[5]

A provider may file an appeal with the Provider Reimbursement Review Board (Board) if it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for a group); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

Historically, the Medicare program reimbursed providers for inpatient hospital services on a reasonable cost basis. The Medicare program currently reimburses providers for their operating and capital-related costs for inpatient hospital services through the inpatient prospective payment system (IPPS).[7] The regulations governing the IPPS continue to require a provider of inpatient hospital services to file an annual cost report based on a provider's accounting period.[8]

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[1] Transcript (Tr.) at 5-6.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1839.
[7] *See* 42 U.S.C. § 1395ww(d).
[8] 42 C.F.R. § 413.20.

The IPPS provides Medicare payment for hospital inpatient operating and capital-related costs based on predetermined rates per discharge derived from average hospital costs. As part of the methodology for determining IPPS payments to hospitals, the Medicare statute requires the Secretary to adjust the wage portion of those payments by a factor reflecting the relative hospital wage level in the geographical location of the hospital compared to the national average hospital wage level.[9] This is accomplished by attributing wage indices to individual hospital geographic locations.

Beginning October 1, 1993, CMS was required to update the wage index annually based on a survey of wages and wage-related costs taken from Worksheet S-3 of the cost reports filed by each hospital paid under IPPS.[10] CMS publishes the wage data used to prepare the wage indices so that hospitals can review them for accuracy. If a hospital disagrees with the accuracy of the data, it may request that the data be corrected and the wage index recomputed. A hospital requesting a correction must do so within a specified time limit and must provide relevant documentation to support the requested correction.[11]

The wage index at issue is for federal fiscal year (FFY) 2006, and it was based on the wage data submitted by hospitals for cost reporting periods beginning in FFY 2002. The instructions governing the FFY 2006 wage index were published in the preamble to the final rule published on August 12, 2005 (August 2005 Final Rule).[12] For purposes of the FFY 2006 wage index, CMS defined hospital labor market areas based on the definitions of statistical areas established by the Office of Management and Budget.[13] The preamble provides a description of the "Computation of the Unadjusted Wage Index" by breaking it up into 11 steps.[14]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cleveland Clinic Hospital (Provider) is an acute care hospital located in Cleveland, Ohio. The Provider appealed from the decision of CGS Administrators LLC ("Intermediary"), formerly AdminaStar Federal, to exclude certain physician Medicare Part A administration costs (Part A Administration costs) reported under time study codes L and O from the Provider's wage data for FY 2002 that was used in calculating the FFY 2006 Wage Index. While the Intermediary refused to include the Part A Administration costs reported under codes L and O in the Provider's cost report for FY 2002, the Intermediary did include similar Part A Administration costs reported under codes L and O in the Provider's FY 2003 cost report. These costs as reported in the FYs 2002 and 2003 cost reports were both based on the same time study and used the same cost report formats. Notwithstanding, the Intermediary reached a different conclusion for each fiscal year.

The Provider maintains that the Intermediary's decision to exclude the Part A Administration costs reported under codes L and O on its FY 2002 cost report was improper and should be

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[9] *See* 42 U.S.C. § 1395ww(d)(2)(H), 1395ww(g)(1)(B)(ii); 42 C.F.R. §§ 412.64(h), 412.316.
[10] *See* 42 U.S.C. § 1395ww(d)(3)(E)(i).
[11] *See* 64 Fed. Reg. 41490, 41512-41513 (July 30, 1999).
[12] 79 Fed. Reg. 47363 (Aug. 12, 2005).
[13] *Id.* at 47363.
[14] *Id.* at 47373-47374.

reversed. The Provider would have received additional reimbursement of approximately $241,711.62, had those costs not been excluded. The Provider requests that the Board reverse the Intermediary's decision to exclude those costs.

The Provider filed a timely appeal with the Board pursuant to 42 CFR §§ 405.1835-1841, and met the jurisdictional requirements of those regulations. The Provider was represented by Lisa G. Han, Esq., of Squire Sanders (US) L.L.P. The Intermediary was represented by Bernard Talbert, Esq., of the Blue Cross and Blue Shield Association.

STIPULATIONS OF THE PARTIES:

The parties reached a joint stipulation of the facts that summarized the issue and concluded that the cases involve no dispute over material facts. Specifically, pursuant to Board Rule 35.1, the Provider and Intermediary stipulated the following facts and issues:

1. The Provider is a single legal entity that operates – (1) a Hospital ("the Cleveland Clinic Hospital"), (2) a Clinic ("the Cleveland Clinic"), and (3) a Research Division.

2. The Provider filed its FY 2002 Cost Report on May 31, 2003. The original Worksheet S-3 reported $9.3 million for Part A physician administrative costs ("Administrative costs") and $1.2 million for Part A physician teaching costs ("Teaching costs"). "Administrative costs" refer to the time spent by physicians performing hospital administrative tasks, such as attending board and committee meetings. "Teaching costs" refer to the time spent by physicians educating residents.

3. After submission of the original FY 2002 Cost Report, the Provider compiled and analyzed data from physician time studies ("Time Study") that had been conducted in 2002 for the purpose of allocating physician salary costs to various activities. Prior to conducting the studies, the Provider submitted the study protocol and survey forms to Intermediary for approval. Intermediary approved the Time Study on September 1, 2001. Intermediary subsequently allowed Provider to amend Worksheet S-3 to reflect the results of the Time Study.

4. On November 29, 2004, Provider submitted a revised Worksheet S-3 to Intermediary that reclassified the costs from Line 98.01 (referring to physician offices), based on the Time Study. The amended Worksheet S-3 also increased the Administrative costs ($30.5 million) and the Teaching Costs ($24.1 million).

5. Specifically, Provider claimed $7,123,708 in wage related costs for physician administrative expense for time study codes L and O. The reimbursement impact on Provider's average hour wage that was used to calculate its FY 2002 reimbursement amount was $3,887,441. Provider also allocated $3,626,367 (45% of Administration costs) to excludable areas for physician time spent in the Clinic or Research Division.

6. Intermediary accepted the amended Worksheet S-3 and relied upon the Time Study to reclassify certain costs, but did not include costs under codes L ("Institution –wide Administration"), O ("Meetings – Non-Medical Administrative") and teaching time in the Wage Index Data ("Wage Index").

7. Intermediary refused to include the costs under codes L and O on the following grounds: (1) the Time Study had been approved for "format," but not "code grouping;" and (2) CCF had submitted no documentation to support its inclusion of costs associated with codes L and O relevant to "hospital-only" and "institution-wide" administrative activities.

8. Intermediary did not include the Administration costs under codes L and O in Provider's 2002 Cost Report, but did include the Administration costs under codes L and O for Provider's 2003 Cost Report that was based on exact same information as provided to the Intermediary for the FY 2002 Cost Report.

9. The exact same Time Study and Cost Report formats were used by Provider for both the FY 2002 and FY 2003 Cost Reports.

10. The issue before the Board is whether the Intermediary's decision to exclude certain physician Part A Administration costs under time study codes L and O from Provider's FY 2002 Wage Data in calculating the FY 2006 Wage Index should be reversed.
11. The reasonably estimated amount in dispute is $241,711.62, which reflects the reimbursement amount Provider would have received if Intermediary had included the costs associated with codes L and O in Provider's FY 2002 Cost Report.[15]

PROVIDERS' CONTENTIONS:

The Provider contends that the allocation of physician compensation attributable to its Part A Administration costs is documented by physician time studies that are in a form that complies with the Intermediary's instructions. Further, the Intermediary approved the use of the forms in its letter dated September 7, 2001 which stated:

> We have reviewed your request for changes in Physicians Time Studies to be used by CCF. It is our judgment that the requested change still meets the guidelines for acceptable Physician Time studies. The revised forms are acceptable for cost reporting purposes.[16]

[15] Stipulation of Facts (citation to exhibit attached to the Stipulation of Facts omitted).
[16] Provider Exhibit P-5 at Tab G.

The Provider maintains that, through this language, the Intermediary plainly accepts the forms and approves their adequacy for documenting time for cost reporting purposes. The Provider contends that it is entitled to rely on the Intermediary's clear expression of approval.[17]

The Provider also argues that all of the FY 2002 Part A Administration costs that were documented by the Intermediary-approved time studies are properly includable on its amended Worksheet S-3 for the FY 2002 cost report. Inclusion of this data, unallocated and unadjusted, is what is required by the wage index calculation process developed by CMS. In that process, CMS itself (not the Intermediary) later allocates this data between hospital reimbursable cost centers and non-reimbursable cost centers. In support of its position, the Provider's Final Position Paper cites to what was then the most recent discussion of the wage index calculation[18] as stated in the preamble to the final rule published on August 11, 2004 for the FFY 2005 wage index.[19] In particular, the Provider refers to the following description of Step 4 used in the "Computation of the Unadjusted Wage Index":

> Step 4—For each hospital reporting both total overhead salaries and total overhead hours greater than zero, *we then allocated overhead costs to areas of the hospital excluded from the wage index calculation.* First, we determined the ratio of the excluded area hours (sum of lines 8 and 8.01 of Worksheet S-3, Part II) to revised total hours (Line 1 minus the sum of Part II, Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, 7 and Part III, Line13 of Worksheet S-3). We then computed the amounts of overhead salaries and hours *to be allocated to excluded areas* by multiplying the above ratio by the total overhead salaries and hours reported on Line 13 of Worksheet S-3, Part III. Next, we computed the amounts of overhead wage-related costs *to be allocated to excluded areas* using three steps: (1) We determined the ratio of overhead hours (Part III, Line 13) to revised hours (Line 1 minus the sum of Lines 2, 3, 4.01, 5, 5.01, 6, 6.01, and 7); (2) we computed overhead wage related costs by multiplying the overhead hours ratio by wage related costs reported on Part II, Line 13, 14, and 18; and (3) we multiplied the computed overhead wage-related costs by the above excluded area hours ratio. Finally, we subtracted the computed overhead salaries, wage-related costs and hours associated with excluded areas from the total salaries (plus wage-related costs) and hours derived in Steps 2 and 3.[20]

The Provider argues that application of the Intermediary's position that only the hospital component should be reported on Worksheet S-3 mishandles the Provider's wage data and would result in an improper decrease of the costs reported on Worksheet S-3 that CMS uses to calculate

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[17] *See* Provider's Final Position Paper at 4-5.

[18] The Board notes that the Provider's Final Position Paper was filed prior to the publication of the instructions for the FFY 2006 wage index. Accordingly, the Provider's Final Position Paper cited to the instructions published for the FFY 2005 wage index.

[19] 69 Fed. Reg. 48915, 49050 (Aug. 11, 2004).

[20] *Id.* at 49050 (emphasis added).

the wage index data for the entire region. Specifically, such an allocation would mean that administrative and general costs would be apportioned twice and, thus, would drastically reduce reimbursement for hospital administrative activities.[21]

Accordingly, the Provider requests that the Board reverse the Intermediary's exclusion of the FY 2002 Part A Administration costs reported under codes L and O.

The Provider points out that in FY 2003, the Intermediary permitted the Provider's Part A Administration costs to be included under codes L and O. Those costs were calculated using the same time study format as that used in FY 2002. Also, the costs included under those codes were exactly the same as those included in FY 2002. The Intermediary acknowledges that the methodology used by the Provider in FY 2002 was identical to that used in FY 2003. Nevertheless, in FY 2003 the costs were included under codes L and O, but in FY 2002 they were excluded[22].

By refusing to include the Part A Administration costs on the FY 2002 cost report, the Intermediary has adversely impacted the FY 2006 Wage Index calculation by drastically reducing the reimbursement amount owed to the Provider for legitimate physician administration activities. In order to preserve the consistency and integrity of the Medicare cost reporting process, the Intermediary's decision to exclude the Provider's FY 2002 Part A Administration costs reported under codes L and O should be overturned and the FY 2006 Wage Index should be adjusted accordingly.[23]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the corrections requested by the Provider were not adequately supported with detailed documentation. In its April 12, 2005 denial letter,[24] the Intermediary explains that the Provider's Part A Administrative costs were identified and reported using codes J, L, M, N, and O. The Intermediary examined the code definitions and determined that only code J could be clearly categorized as hospital administration. The Provider's physician time study booklet provides the following definition for code L:

> Institution-wide administration is time spent on similar activities as described in J, but which focus primarily on administrative responsibilities that are 'institution wide" in nature. This could include activities such as the Board of Governors, Safety Committee, Medical Executive Committee, etc.[25]

The same booklet provides the following definition for code J:

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[21] *See* Provider's Final Position Paper at 5-6.
[22] *See* Provider's Post Hearing Brief at 4-5.
[23] *See id.* at 5.
[24] Provider Exhibit P-3.
[25] Provider Exhibit P-5 at Tab E (April 12 2005 letter from the Intermediary to the Provider quoting the Provider's physician time study booklet). *See also* Intermediary's Final Position Paper at 7 (quoting the Provider's physician time study booklet).

> Laboratory Medicine physicians should use this code to record all administrative time unless it is institution-wide. Anesthesiology and radiology physicians will primarily use this code also, unless it is clinic related or institution-wide.[26]

The Intermediary argues that the institution-wide administration activities reported under code L covers all areas of the Cleveland Clinic Foundation ("CFF") health system. This system includes not only the Provider (*i.e.*, the CCF hospital) but also the CCF clinic, CCF Research, CCF Florida and CCF Health System member hospitals. The Intermediary disputes the Provider's classification of the codes as pertaining solely to the hospital (Provider). It argues that for codes L and O, the physician time studies must distinguish between the time spent in hospital and non-hospital areas. The Intermediary further contends that the Provider has offered no methodology as to how the time spent by physicians in institution-wide administration would be allocated between the hospital and non-hospital areas.

The Intermediary states that the Provider submitted no documentation to support the inclusion of Part A Administration costs related to physician time in codes L and O in hospital-only Medicare Part A administrative activities nor documentation to support the allocation of institution-wide administration between the hospital and non-hospital entities.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law, regulations and guidelines, the parties' contentions and stipulations, and the evidence presented at the hearing, finds and concludes that the Intermediary improperly excluded Part A Administration costs under time study codes L and O from the Provider's wage index data for FY 2002.

In the issue presented before the Board, the Intermediary raised two assertions that required the Board's consideration. The first involved the adequacy of the time studies that the Provider used to develop its physician cost allocation. It is undisputed that the Provider submitted its time study protocols and forms to the Intermediary for its evaluation and approval prior to their implementation generally and prior to their use for the FY 2002 cost report.[27] It is also undisputed that the Intermediary approved those time study protocols on September 1, 2001.[28] The dispute relative to the time study protocols centers on the scope of the Intermediary's approval. The Intermediary asserts that the time study protocol had been approved for format but not code groupings.[29] The Provider argues that the plain language of the Intermediary's approval[30] accepts the forms and their adequacy for documenting physician time for cost reporting purposes. The language clearly includes approval of the code groupings.

The Board has examined the Intermediary's approval and notes that the operative language is that the Provider's forms "meet the guidelines for acceptable Physician Time studies" and "are

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[26] Provider Exhibit P-5 at Tab E (April 12 2005 letter from the Intermediary to the Provider quoting the Provider's physician time study booklet).
[27] Stipulations at ¶ 3.
[28] *Id.*
[29] Stipulations at ¶ 7.
[30] Provider Exhibit P-5, Tab G.

acceptable for cost reporting purposes." The Board can find nothing in the language of the Intermediary's approval that limits the application or use of the Provider's forms in the cost reporting process. Further, the Board can find no evidence that the Provider received notice of any limitation on the Intermediary's approval prior to conducting and filing its time study for FY 2002. The Board further notes that the Provider utilized the very same time study protocols in *subsequent* years and those time studies were accepted without challenge by the Intermediary.[31]

Accordingly, the Board considers the Intermediary's interpretation for FY 2002 inconsistent with the language of its own approval and with its subsequent audit practices. The Board also finds that the Intermediary's position for FY 2002 is unsupported by the necessary notice to compromise the Provider's reliance on its unqualified acceptance. The Board concludes that the Intermediary's position for FY 2002 is arbitrary and that it was improper to disallow the Provider's allocation methodology.

The Intermediary further contends that the cost report instructions require that Part A Administration costs (reported under time study codes O and L) should be allocated between hospital and other non-reimbursable cost centers before being entered on Worksheet S-3. The Intermediary asserts that only the hospital component be reported on Worksheet S-3 and that the Provider had submitted no documentation to support its inclusion of costs associated with codes L and O relevant to "hospital-only" and "institution-wide" administrative activities. The Provider challenges the Intermediary's position and argues that it allocates its costs to both hospital reimbursable cost centers as well as excluded or non-reimbursable cost centers based upon CMS's wage index computation.

The wage index computation for the FFY 2006 wage index is described in the August, 2005 Final Rule. The Board examined the language of the August, 2005 Final Rule, the testimony at the hearing relative to the Provider's application of this final rule, and the other evidence of record.[32] Based on this examination, the Board agrees with the Provider that Step 4 of the wage index computation instructions for FFY 2006 does in fact make the allocation of total administrative costs among hospital and non-reimbursable centers that the Intermediary contends must be made independent of Worksheet S-3.[33] Accordingly, application of the wage index computation instructions delineated in that final rule effectively eliminates the need for the adjustment proposed by the Intermediary. Further, testimony confirms that the Provider made the adjustments in its cost reporting process to bring its cost report submission into compliance with the requirements of the final rule.[34]

The Board concludes that the Provider properly applied the final rule and properly allocated its total administrative costs among hospital and non-reimbursable centers. The Intermediary position that Part A Administration (reported in time study codes O and L) should be allocated between hospital and other non-reimbursable cost centers prior to being entered on Worksheet S-

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[31] Stipulations at ¶ 8.
[32] Tr. at 39-51.
[33] The Board notes that the description of Step 4 used for the FFY 2006 wage index calculation is virtually identical to that used for the FFY 2005 wage index calculation.
[34] Tr. at 48-50.

3 is inconsistent with the August, 2005 Final Rule and may not be used to support an audit disallowance.

DECISION AND ORDER:

The Intermediary accepted the Provider's time study forms and their adequacy for documenting time for cost reporting purposes in advance of their use for FY 2002. The Intermediary's acceptance was without any qualification or limitation. The Board considers the Intermediary's FY 2002 disallowance inconsistent with the language of its own approval and unsupported by the necessary notice to compromise the Provider's reliance on its unqualified acceptance. It was improper for the Intermediary to disallow the Provider's allocation methodology.

The Provider properly applied the wage index computation instructions stated in the August, 2005 Final Rule and properly allocated its total administrative costs among hospital and non-reimbursable centers. The Intermediary position that Part A Administration costs should be allocated between hospital and other non-reimbursable cost centers before being entered on Worksheet S-3 is inconsistent with that final rule and may not be used to support an audit disallowance. Accordingly, the Intermediary's disallowance is reversed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
J. Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 06 2013