PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D29

PROVIDER –
Community Hospital of Anaconda
Anaconda, Montana

Provider No.: 27-1335

vs.

INTERMEDIARY –
Noridian Administrative Services/
Blue Cross and Blue Shield Association

DATE OF HEARING -
February 16, 2012

Cost Reporting Period Ended -
December 31, 2005

CASE NO.: 08-0050

INDEX

ISSUE:

Whether the Medicare Administrative Contractor's disallowance of the Provider's certified registered nurse anesthetist on-call costs was proper.[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 of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals . Title XVIII of the Act is codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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, regulation and interpretative 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 period and the portion of those costs allocated to the Medicare program.[4] Each 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").[5] A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") provided 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 groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

Medicare reasonable cost reimbursement is governed by 42 U.S.C. § 1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. § 413.9 specifies that the "reasonable cost" includes all "necessary and proper" costs incurred in furnishing healthcare services. 42 C.F.R. § 413.70 provides that providers designated as

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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] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 – 405.1837.

Critical Access Hospitals ("CAH") will be paid the "reasonable cost" for patient services to Medicare beneficiaries. In addition, 42 C.F.R. § 412.113(c) provides that payment for anesthesia services obtained under arrangements with certain qualified non-physician anesthetists, including but not limited to certified registered nurse anesthetists ("CRNAs"), will be determined on a reasonable cost basis.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Community Hospital of Anaconda ("Provider") is a rural hospital that is located in Anaconda, Montana and participates in the Medicare program as a CAH. The Provider contracted with an independent third party to oversee its Anesthesia department and provide CRNA services. The third party provided on-site services for the benefit of the Provider and its medical staff as well as on-call related services. For its fiscal year ending December 31, 2005 ("FY 2005"), the Provider claimed $65,689 for the payments that it made to its third party contractor for on-call related services. Noridian Administrative Services ("Intermediary") conducted an examination of the Provider's claimed costs and disallowed the amounts claimed for CRNA on-call costs in their entirety for FY 2005.

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§ 405.1835-405.1841 and met the jurisdictional requirements of those regulations. The Provider was represented by Michael R. Bell, C.P.A.. The Intermediary was represented by Bernard Talbert, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its request for CRNA cost-based reimbursement is allowable under the provisions of 42 C.F.R. § 412.113.[7] The Provider asserts that it applied for and received approval from the Intermediary for cost-based reimbursement for its CRNA services under this regulation.[8]

Further, the Provider challenges the Intermediary's reliance on 42 C.F.R. § 413.70(b)(4)(ii)(B) and the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2109 to disallow the on-call costs at issue. The Provider argues that these authorities apply only to emergency room physicians and mid-level practitioners and do not reduce or replace Medicare's reasonable cost reimbursement rules that apply to CRNA costs.[9]

The Provider contends that on-call costs associated with CRNA services are allowable program expenses in accordance with 42 U.S.C. § 1395x(v)(1)(A).[10] In part, the statute

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[7] Tr. at 8.
[8] Tr. at 8-9.
[9] Tr. at 9-12.
[10] Although standby costs associated with nurses, laboratory technicians, and other hospital staff are not at issue in this case, the Provider asserts that the Medicare program routinely reimburses providers for these individuals' standby time and that these costs have never been questioned by intermediaries. *See* Provider Final Position Paper at 3-5.

states that "standby" costs are allowable unless they are found to be "unnecessary in the efficient delivery of services." The Provider also cites to two regulations that it contends provide support to its interpretation of § 1395x(v)(1)(A). First, the Provider cites to 42 C.F.R. § 413.5 which is entitled "*Cost reimbursement: General*" and states in subsection (a): "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized." The Provider also cites to 42 C.F.R. § 413.9(c)(3) which states in pertinent part: "[r]easonable cost includes all necessary and proper expenses incurred in furnishing services . . . . It includes both direct and indirect costs and normal standby costs."[11]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the pertinent statute, 42 U.S.C. § 1395x(v)(1)(A), confirms that not all standby costs are necessary in the efficient delivery of health care services. In the context of the statute, the Secretary promulgated 42 C.F.R. §§ 413.5 and §413.9 and PRM 15-1 §§ 2102.1 and 2109, allowing standby costs in certain circumstances which include costs associated with unoccupied beds and the allocation of costs between certified and non-certified beds (PRM 15-1 § 2342), and assets that have been retired but held for emergency use (PRM 15-1 § 130).[12] With respect to CAHs, 42 C.F.R. § 413.70(b)(4) allows standby costs associated with emergency room physicians and certain midlevel practitioners that does not include CRNAs. The Intermediary argues that CRNA standby costs are not covered by the instructions and, as a result, the Medicare program does not recognize it as the normal standby cost under § 413.9.[13]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes, as explained more fully below, that the intermediary's disallowance of CRNA standby costs was improper.

The Provider entered into a professional services agreement with Tobacco Root Anesthesiology to provide "coverage of the anesthesia department of [the Provider] so that coverage is available 24 hours daily every day" and "[t]he predominant form of coverage will be 7 days on and 7 days off shared by the two anesthetists."[14] The contract further specified that Tobacco Root Anesthesiology "will be paid $150,000 per year for the coverage requirements." Thus, the contract is paying for "coverage" on a *prospective* basis. Based on its review of the contract and the hearing record, the Board concludes that the intent of the contract was not to pay for on-call services (*e.g.*, paying someone to sit at home) but rather to pay for the performance of anesthesiology services (*i.e.*, direct patient care services).

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[11] Provider Final Position Paper at 2.
[12] Intermediary Position Paper at 4-5.
[13] *See id.*
[14] Intermediary Exhibit I-7 at 2 (copy of Provider's contract with Tobacco Root Anesthesiology).

The historical demand for CRNA services was for 800 to 1000 hours[15] and, for FY 2005, it was just above that range at 1016 hours.[16] However, as the Provider is a CAH and has sporadic demands for surgical services and related anesthesiology, the Provider could not predict when those CRNA services were actually needed.[17] Accordingly, the *prospectively*-set compensation to Tobacco Root Anesthesiology may include a certain premium for the CRNA's immediate availability to provide anesthesiology services when the actual need arises. The Board finds that this is no different than the premium built into the hourly rate paid to a temporary staffing agency for the immediate availability of staff to perform services on an as-needed basis (*e.g.*, nurse staffing pools).[18] Accordingly, the Board finds that the Intermediary improperly disallowed the costs incurred by the Provider for contracted CRNA services for FY 2005 as standby costs. Rather, as explained above, the contracted CRNA services were for the performance of actual CRNA services and did not include payment of a standby component.

In the alternative, even if the compensation could be construed as including a payment for standby costs, the Board would find that such costs would be allowable. The issue of standby costs is not new to the Board. In 2009 in *St. Luke Community Healthcare vs. BlueCross BlueShield Ass'n* ("*St. Luke*"),[19] the Board addressed similar circumstances and arguments. Based upon its holdings in *St. Luke* and its consideration of the arguments in this case, the Board finds and concludes that there is no statute, regulation or guideline which specifically addresses whether CRNA standby costs incurred by a CAH are allowable. However, the Board finds that there are several authorities which, when read together, provide for the payment of CRNA standby costs. These provisions are as follows:

1. 42 U.S.C. § 1395x(v)(1)(A), as conceded by the Intermediary, recognizes that standby costs may be reasonable or necessary costs. Specifically, this section instructs that the Medicare reasonable cost regulations shall "take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, *including standby costs*, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services . . .) . . . ."[20]

2. The reasonable cost regulation at 42 C.F.R. § 413.9(c)(3) refers to "normal standby" cost. The regulation reads in pertinent part: "The determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses

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[15] *See id.*
[16] *See* Intermediary Exhibit I-8 at 26 (Intermediary workpaper for its FY 2005 audit of the CRNA services).
[17] *See* Provider Post Hearing Brief at 2. *See also* Provider Exhibit P-7 at 34-35, 41 (transcript for *St. Luke Community Healthcare v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2009-D09 (Feb. 25, 2009).
[18] *See* GAO Letter to HCFA, "Effect on Use of Nursing Pools," CCH Medicare & Medicaid Guide 1981-2 Med-Guide-TB ¶ 31,425 (Feb. 18, 1981).
[19] PRRB Dec. No. 2009-D09 (Feb. 25, 2009) (copy included as Intermediary Exhibit I-11), *rev'd*, CMS Administrator Dec. (Apr. 23, 2009) (copy included as Intermediary Exhibit I-12), *aff'd*, No. CV 09-92-M-DWM-JCL, 2010 WL 1839411 (Apr. 14, 2010), *aff'd*, No. CV 09-92-M-DWM, 2010 WL 1839405 (May 5 2010) (copy included as Intermediary Exhibit I-13).
[20] (Emphasis added.)

incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs *and normal standby costs*."[21]

3. PRM 15-1 § 2102.1 defines the term "reasonable costs" and includes the term "standby costs" in its discussion of reasonable costs. Specifically, this manual provision states, in pertinent part: "Reasonable cost takes into account both direct and indirect costs of providers of services, *including normal standby costs*."[22]

4. The 1970 memorandum of Thomas Tierney, Director of the Bureau of Health Insurance[23] discusses the relationship between occupancy rates and reasonable costs and, in particular, states:

> Disallowance of provider costs as unreasonable solely on the basis that occupancy falls below a given level seems at variance with the intent expressed in the Senate report on the 1965 amendments (pages 35-36) to the effect that reasonable costs are actual costs unless they are substantially out of line with those of comparable institutions "similar in size, scope of services, *utilization* and other relevant factors" (emphasis supplied). On the other hand, it is clear that simply accepting excessive costs arising from low occupancy would be inconsistent with the intent to meet only "normal" standby costs. What is required in this legal framework is not blanket disallowance of excess cost flowing from low occupancy, but rather disallowance of excess costs flowing from low occupancy *to the extent they are, in fact, unreasonable.* . . . In most cases, the principle variable that is subject to provider control when occupancy is low will be staffing levels.

The Board finds nothing in the above references that specifically precludes standby costs from being included in reasonable cost. Rather, the Board concludes that the statute, regulations and program instructions contemplate that normal standby costs are considered reasonable costs. Indeed, the Board notes that the need for standby services is critical in CAHs as its volume may be sporadic and it may have periods when it is closed because there are no inpatients.[24] In this regard, the CAH conditions of participation *only*

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[21] (Emphasis added.)
[22] (Emphasis added.)
[23] Attachment to the letter of the Commissioner of the Medical Services Administration in the Social Security Administration (June 5, 1970) (*available at* CCH Medicare & Medicaid Guide, 1972 Med-Guide-TB ¶ 26,127).
[24] *See* 58 Fed. Reg. 30630, 30653-30654 (May 26, 1993). In particular, the preamble to this final rule states:

> *Comment:* One commenter stated that it may not be appropriate to allow a facility that is responsible for 24-hour emergency care to close down, since lack of on-site personnel may jeopardize the quality of initial decision-making and of the subsequent care that is

require "a registered nurse, clinical nurse specialist or licensed practical nurse [be] on duty whenever the CAH has one or more inpatients."[25] Therefore, the Intermediary's conclusion that the controlling reasonable cost principles allow only those standby costs that are specifically identified as allowable is without merit.

The Intermediary relied on 42 C.F.R. § 413.70 entitled "Payment for services of a CAH" to support its position that CRNA standby costs are not specifically identified as "allowable," and that such costs must, therefore, be "non-allowable." The section of the regulation the Intermediary argues is pertinent to this case is § 413.70(b)(4) entitled "Costs of certain emergency room on-call providers." However, this regulatory provision as confirmed by its title, is specific to and limited to on-call providers in an emergency *room* setting. The Board finds that the evidence in this case is consistent with what the Board understands to be typical of CRNA services, which is that, generally, CRNAs would not work in an emergency *room* setting.[26] Therefore, CRNAs would not be considered emergency *room* personnel under 42 C.F.R. §413.70(b)(4) and this regulation would not apply to CRNA standby services. This is not to say that CRNAs are not involved in emergency or urgently-needed services. Rather, such unscheduled services tend to be provided in connection with inpatient services in the surgical department (*e.g.*, patient transferred from emergency room to inpatient admission for emergency surgery).

The Intermediary also relied on PRM 15-1 § 2109 to support its argument prohibiting standby costs for CRNA's under service arrangements. However, upon reviewing § 2109, the Board notes that this section is entitled "Emergency Department Services" and finds that this section deals exclusively with reasonable compensation for services provided by *physicians* under a service agreement in connection with "Emergency Department Services" only. The Board can find no indication that this section applies to any other service arrangement, including those outside the emergency room, and, accordingly, finds that this section is not applicable to the circumstances of this case.

As the Board has found that 42 C.F.R. §413.70(b)(4) does not apply and, therefore, does not preclude the Provider from claiming CRNA standby costs, the Board looks to 42

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provided (56 FR 55392). However, other commenters stated that as long as a mechanism is in place to assure responsiveness to emergencies, it is generally appropriate to allow an RPCH to close when it has no inpatients.
Response: We agree that a facility that is staffed and open at all times generally will be able to provide a higher level of emergency responsiveness than one which closes for certain periods and has personnel available only on an on-call basis. However, we also recognize that rural facilities may find it very difficult to recruit and pay the personnel needed to provide on-site 24-hour emergency services and are concerned that some otherwise qualified facilities might be unable to participate if they were required t o remain open at all times. Therefore, we did not revise the regulations based on these comments.

Id. at 30653.

[25] 42 C.F.R. § 485.631 (2006).

[26] *See, e.g., Marias Medical Center v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Montana*, PRRB Dec. No. 2008-D40 (Sept. 29, 2008) (finding that less than 1 percent of CRNA services were performed in the emergency room) (copy included as Intermediary Exhibit I-9), *rev'd*, CMS Administrator Dec. (Nov. 21, 2008) (copy included as Intermediary Exhibit I-10).

C.F.R. § 412.113(c) which specifically allows CAHs and rural hospitals to use CRNAs and to be paid on a reasonable cost basis. The Provider has maintained that it met all the requirements for the reimbursement of reasonable costs for CRNA services, which in this specific case included services provided under arrangement and, under this alternative ruling, standby costs.[27] The Provider also asserts that contracting with a CRNA to provide services under arrangement, including paying standby costs, actually saved the Provider money when compared to hiring a CRNA on staff. The Board finds that both 42 C.F.R. § 413.9 and CMS Pub.15-1 § 2102.1 attempt to limit expenditures by adopting a prudent buyer principle. CMS Pub. 15-1 §2102.1 reads:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that *the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service.* (See §2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.[28]

The Board finds that the Provider's business decision to use a contracted CRNA and incur the standby costs at issue was an attempt to limit its costs and pay only what a "prudent and cost conscious buyer" would pay for CRNA services. Therefore, these standby costs met the reasonable cost standards of 42 C.F.R. § 413.9 and PRM 15-1 § 2102.1 and the costs are allowable under the Medicare program.

Finally, the Board finds no evidence that it was "longstanding" CMS policy to never allow unspecified standby costs, and finds support in the statute, regulations and program instructions that the opposite is true provided the standby costs were reasonable and necessary. In the regard, the Board supplements the previously cited materials with the following:

1. PRM 15-1 § 2135.2 addresses the allowability of purchased management and administrative support services and specifies that: "A contract fee may provide for availability of services on an as needed or standby basis (e.g., access to national purchasing program) which may or may not be utilized. *Ordinarily, costs for standby services will be recognized if reasonable in amount and related to patient care.*"[29]

2. In connection with HCPCS for hospital outpatient radiology services and other diagnostic procedures, the Medicare Intermediary Manual, CMS Pub No. 13-3 ("MIM 13-3"), § 3631(C)(3)(d) specified in 2003 the following with regard to "on call" charges:

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[27] Tr. at 8-13.
[28] (Emphasis added.)
[29] (Emphasis added.)

d. "On Call" Charges.—These are not billed separately. The appropriate code for the performed procedures must be reported. Codes related to on call personnel may be included on the cost report and may be spread across individual charges related to the personnel.[30]

3. 42 C.F.R. § 414.352.—The regulations governing laboratories define a "qualified hospital laboratory as one that, among other things, "[h]as staff on duty or *on call* 24 hours a day, 7 days a week, to perform clinical diagnostic tests to serve a hospital emergency room."[31]

This finding is further supported by the Provider's testimony that the hospital is routinely cost reimbursed for other types of employee and contractor standby costs, such as laboratory staff and radiology technicians despite there being no specific reference to these standby services.[32] In this regard, the Board notes that, during 2005, the CAH Survey and Interpretive Guidelines recognized that CAHs may have much of its personnel "on call" by directing the surveyors to review during the entrance conference the CAH's "[o]n-call schedules for physicians, other staff (e.g., mid-level practitioners, laboratory, imaging, etc.), for the past three months."[33] The Board finds that since the CRNAs who meet the requirements of 42 C.F.R. § 412.113(c) are paid on a reasonable cost basis, their standby costs would be reimbursed similarly to these other hospital staff.

DECISION AND ORDER:

The Intermediary improperly disallowed the standby costs incurred by the Provider for contracted CRNA services for FY 2005. The Intermediary's disallowance is reversed.

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[30] MIM 13-3 § 3631(C)(3)(d) (as it existed prior to Transmittal 1904 (Oct. 31 2003)). *See also* Hospital Manual, CMS Pub. No. 10, §443(C)(3)(d) (as it existed prior to Transmittal 808 (Nov. 10, 2003) relative to HCPCS for hospital outpatient radiology services and other diagnostic procedures) (stating verbatim what is in MIM 13-3 § 3631(C)(3)(d)); Skilled Nursing Facility Manual, CMS Pub. No. 12, § 533.1(D) (as it existed prior to Transmittal 378 (Nov. 10, 2003) relative to Medicare Part B radiology services and other diagnostic procedures) (stating verbatim what is in MIM 13-3 § 3631(C)(3)(d)).

[31] (emphasis added) (as proposed by 58 Fed. Reg. 43832 (Aug. 18, 1993) and finalized by 59 Fed. Reg. 32086 (June 22, 1994)). *See also* Medicare Intermediary Manual, CMS Pub. No. 13-3, § 3628; Hospital Manual, CMS Pub. No. 10, § 437.

[32] Tr. at 13-21. *See also* Exhibit P-7 at 36-39 (transcript for *St. Luke Community Healthcare v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2009-D09 (Feb. 25, 2009).

[33] SMM, Appendix W, Medicare Rural Hospital Flexibility Program, Part I at IV(B)(3) (as revised by Transmittal 9 (May 1, 1999) (pertains to CAH Survey "Task 2 - Entrance Conference"). *See also* SMM, Appendix W, Medicare Rural Hospital Flexibility Program, Part II at Exhibit 2 (as revised by Transmittal 9 (May 1, 1999) (model letter to notify CAH regarding scheduling a survey and to make available the on-call schedules of physicians and other staff as noted in CAH Survey Task 2).

Board Members Participating:

Michael W. Harty
John Gary Bowers, C.P.A.
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FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 24 2014