PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2019-D22

PROVIDER – Mariners Hospital

PROVIDER NO.: 10-1313

vs.

MEDICARE CONTRACTOR –
First Coast Service Options, Inc.

HEARING DATE – April 30, 2018

Cost Reporting Period Ended –
2012, 2013, 2014

CASE NOs. –
15-3311, 16-2022, 16-2024

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor improperly disallowed costs incurred by the Provider under its service agreements with emergency and anesthesiologist physicians groups for availability, standby, and administrative services furnished to the hospital.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly classified payments made by Mariners Hospital ("Mariners" or "Provider") for emergency and anesthesiologist service agreements as Part B costs for the fiscal years ending ("FYE's") September 30, 2012,[2] September 30, 2013,[3] and September 30, 2014[4] (hereinafter "FYs 2012, 2013, and 2014"). Accordingly, the Board remands the cost reports for these fiscal years back to the Medicare Contractor to properly classify the payments made for these services as Part A provider costs.

INTRODUCTION

Mariners is a 25-bed Critical Access Hospital ("CAH") located in the Florida Keys (in Tavernier, Florida). Mariners furnishes emergency services as required under the Medicare conditions of participation for CAHs. As such, Mariners must make emergency services available 24 hours per day, 7 days a week, and have physicians available to provide those services. Mariners also performs surgical services, including unscheduled emergency surgeries, and must ensure adequate coverage by sufficient numbers of individuals qualified to administer anesthesia.[5] Because of its remote location and it fluctuations in patient volumes Mariners contracted with Anesthesia Associates of Greater Miami ("Anesthesia Associates") to provide anesthesia services and with Criticare, Inc. ("Criticare") to provide emergency services.[6]

Mariners' assigned Medicare administrative contractor is First Coast Service Options, Inc. ("Medicare Contractor").[7] For Mariners' FYs 2012, 2013, and 2014, the Medicare Contractor disallowed the contracted anesthesia and emergency services. The Medicare Contractor made these adjustments because Mariners did not submit allocation agreements that distinguished between Medicare Part A ("Part A") services to Mariners and Medicare Part B ("Part B") services furnished to individual patients.[8] Specifically, because there were no allocation

[1] Stipulations at ¶ 1.
[2] PRRB Case No. 15-3311.
[3] PRRB Case No. 16-2022.
[4] PRRB Case No. 16-2024.
[5] *See* Provider's Consolidated Final Position Paper at 2(citing 42 C.F.R. §§ 485.639(c), 485.618).
[6] *Id.* at 3.
[7] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[8] Medicare Contractor's Final Position Paper (FYs 2012, 2013, 2014) at 5-6.

agreements, the Medicare Contractor presumed that all the costs incurred under the Anesthesia Associates and Criticare contracts were for Part B professional services to patients.[9]

Mariners timely appealed the disallowance of these costs to the Board and met the jurisdictional requirements for a hearing. The Board conducted a Record hearing on April 30, 2018. Mariners was represented by Christopher L. Keough, Esq. of Akin Gump Strauss Hauer & Feld, LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW:

Most of the facts of this case are undisputed. Mariners is certified by Medicare as a CAH.[10] The Medicare conditions of participation for CAHs require, among other criteria, that the provider ensures that emergency services are available to inpatients and outpatients 24 hours per day, 7 days a week, and further, that qualified medical personnel be available on call and immediately available by telephone or radio contact, and available on site within 30 minutes.[11] Medicare's conditions of participation for CAHs also require that the provider ensures adequate coverage for anesthesia services by qualified medical personnel.[12]

Mariners entered into agreements with Anesthesia Associates to provide "medical administrative services… [and] the availability of Anesthesia Services",[13] and with Criticare to provide "medical and administrative services… [and] the availability of Emergency Medicine Services."[14] Mariners' agreements with Anesthesia Associates and Criticare require the physician groups to make physicians available to Mariners' patients, as needed, 24 hours per day every day of the week, on an exclusive basis. In addition, the contractors are required to provide certain other administrative services to Mariners, including the provision of a medical director.[15] The contractual payments made by Mariners to the physician groups cover these availability and administrative services to the hospital.[16] Both the Criticare and Anesthesia Associates agreements provide that the physician groups *separately* bill and collect payments for the professional services rendered to Mariners' patients.[17]

As a CAH, Mariners is reimbursed for inpatient and outpatient services on a reasonable cost basis.[18] The Medicare statute defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."[19] The intent of the reasonable cost statute, which has been in place since the

---

[9] *See* Exhibit P-1 (FY 2012) at Audit Adjustment Nos. 7, 9; Exhibit P-1 (FY 2013) at Audit Adjustment No. 8; Exhibit P-1 (FY 2014) at Audit Adjustment Nos. 9, 12.
[10] Stipulations at ¶ 2.
[11] *Id.* at ¶ 4; 42 C.F.R. §§ 485.618(a), (d).
[12] Stipulations at ¶ 5; 42 C.F.R. § 485.639(c).
[13] Exhibit P-4 at 2.
[14] Exhibit P-2 at 2.
[15] Stipulations at ¶ 9.
[16] *Id.* at ¶ 10.
[17] *Id.* at ¶ 11.
[18] *See* 42 U.S.C. §§ 1395f(*l*), 1395m(g)(1); 42 C.F.R. §§ 413.70(a)(1), (b)(2)(i).
[19] 42 U.S.C. § 1395x(v)(1)(A).

beginning of the Medicare program, is "to meet the *actual* costs" incurred in rendering necessary services, "including normal standby costs."[20] Under this fundamental precept, a provider's *actual* incurred costs may be nonetheless limited when "a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors."[21]

Consistent with Congressional intent to reimburse CAHs for their actual costs incurred, the regulation implementing reasonable cost reimbursement provides that "[r]easonable cost includes all necessary and proper costs incurred in furnishing the services…"[22] The regulation broadly defines the term "necessary and proper costs" to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities."[23] Consistent with the intent of the statute, the implementing regulations include "standby costs" and "administrative costs" within the definition of reasonable costs.[24] Moreover, the regulations expressly define reasonable costs in a CAH to "include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved," provided the emergency room physician "is not otherwise furnishing physicians' services, and is not on call at any other provider or facility."[25]

The dispute in this case involves the application of the Medicare reasonable cost reimbursement rules to Mariners' physician availability contracts with Criticare and Anesthesia Associates.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor relies on the regulation at 42 C.F.R. § 415.60(f)(2), which states, in part: "In the absence of a written allocation agreement, the intermediary assumes, for purposes of determining reasonable costs of the provider, that 100 percent of the physician compensation cost is allocated to services to beneficiaries as specified in paragraph (b)(2) of this section." In this instance, because no allocation agreement was produced by Mariners, the Medicare Contractor relied on this regulation and allocated all of the physician service costs related to the Anesthesia Associates and Criticare contracts to the Part B professional component on Worksheet A-8-2 of the cost report.

The Medicare Contractor contends that the payments made under the Criticare and Anesthesia Associates contracts include payments for services associated with the provision of professional

---

[20] S. Rep. No. 89-404, pt. 1, at 35-36 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1976 (emphasis added).
[21] Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2102.1 ("It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization and other relevant factors.")
[22] 42 C.F.R. § 413.9(a).
[23] 42 C.F.R. § 413.9(b)(2).
[24] 42 C.F.R. § 413.9(c)(3). *See also* 42 C.F.R. § 413.5(a) (stating that payment on a reasonable cost basis is meant to include "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs.").
[25] 42 C.F.R. § 413.70(b)(4)(i).

services to patients.[26] The Medicare Contractor points to the Criticare contract which defines the term "Emergency Medicine Services" as "the professional services of physicians in the specialty of emergency medicine customarily provided by such physicians, whether in the Emergency Department or elsewhere in the Hospital or on the MH campus…."[27] The Medicare Contractor also observes that the contract requires that "Emergency Medicine Services" include "being available twenty-four (24) hours per day, seven (7) days per week, to provide Emergency Medicine Services and to respond to code blues and any other code rescue situations occurring in the Hospital or on the [Mariners] campus, including but not limited to, the Tassell Medical Arts Building in accordance with the Hospital's policies and procedures."[28]

The Medicare Contractor further argues that these physician group services included direct patient care that was not necessarily related to Part A provider services.[29] The Medicare Contractor notes that the contract for Anesthesia Services states, "Contractor shall provide Anesthesia Services for all emergency and elective Patients, and for all other services that may require the services of a Physician (as determined in accordance with Hospital Governing Documents)."[30] The Medicare Contractor contends this contract is not related strictly to Part A provider services, as Part B services to patients are included in these services.[31] Since Mariners did not submit a written allocation of the time spent on the Part A provider component versus the Part B professional component, the Medicare Contractor believes it was mandated by regulation to disallow all the contract costs.[32]

The Medicare Contractor emphasizes that it did not make these adjustments due to "unreasonable" costs.[33] The Medicare Contractor adjusted the physician costs on Worksheet A-8-2 in order to reclassify the costs associated with these agreements as professional services provided under Part B.[34] The Medicare Contractor states that it will consider splitting out the costs between Part A and Part B pending receipt of documentation showing that a written allocation was completed by Mariners.[35]

Mariners contends the contractual payments it made to the physicians groups do not cover physicians' professional services to patients.[36] Mariners further contends that, under the agreements, it pays the physician groups only for the availability, standby and administrative services furnished to Mariners, not for the Part B professional services that may be furnished to individual patients by the contracted physicians.[37] In support, Mariners points out that the

---

[26] Medicare Contractor's Final Position Paper at 5-6.
[27] *Id.*
[28] *Id. See also* Exhibit I-1 at 3.
[29] Medicare Contractor's Final Position Paper at 5.
[30] *Id.* at 6. *See also* Exhibit I-2 at 1.
[31] Medicare Contractor's Final Position Paper at 6.
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.* at 7.
[36] Provider's Consolidated Final Position Paper at 4; Exhibit P-3 at §§ 5.1, 5.7; Exhibit P-4 at §§ 5.1, 5.7.
[37] *Id.*

agreements state that the contractor shall bill and collect for services furnished to individual patients.[38]

The Board finds that the Medicare Contractor improperly disallowed Mariners' contracted emergency room and anesthesia costs because the availability and administrative services at issue are not for physicians' professional services payable under Part B. Rather, the record is clear that these costs relate *solely* to services provided to Mariners and reimbursable under Part A. In this regard, the Criticare and Anesthesia Associates contracts are clear that Mariners makes ***no*** payments to either Critcare or Anesthesia Associates for Part B services.[39] Rather, these contracts expressly provide for the physicians to bill all patients *directly* for the physician services furnished to them and the physician personally received payment from or on behalf of the patients – not from Mariners.[40] Because *all* of the services Mariners paid for under the agreements with Anesthesia Associates and Criticare were for Part A services to the Provider (*i.e.*, there was nothing to allocate to Part B), Mariners was not required to enter into an allocation agreement with the emergency room and anesthesia physicians to allocate the costs between Part A services to Mariners and Part B professional services to patients.

The Board recognizes that the regulation relied upon by the Medicare Contractor to make the disputed adjustments states:

> (b) *General rule.* Except as provided in paragraph (d) of this section, each provider that incurs physician compensation costs must allocate those costs, in proportion to the percentage of total time that is spent in furnishing each category of services, among—
>
> (1) Physician services to the provider (as described in §415.55);
> (2) Physician services to patients (as described in §415.102); and
> (3) Activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.[41]

However, this regulation is subject to an exception that is relevant to this case. Specifically, paragraph (d) of § 415.60 provides an exception to the general rule to allocate services furnished by the physician among Part A, Part B and non-covered costs, when, "(1) The provider certifies that the compensation is attributable *solely* to the physician services furnished to the provider; and (2) The physician bills all patients for the physician services he or she furnishes to them and personally receives the payment from or on behalf of the patients. . . ."[42] As explained below, the Board finds this exception applies to the facts of these appeals.

Mariners has maintained *and certified*, repeatedly, that all of the payments made under the Anesthesia Associates and Criticare agreements are attributable solely to the physicians' services

---

[38] Provider's Consolidated Final Position Paper at 4-5; Exhibits P-2 at § 5.1; Exhibit P-4 at § 5.1.
[39] *Id.*
[40] Stipulations at ¶ 11.
[41] 42 C.F.R. § 415.60(b).
[42] 42 C.F.R. § 415.60(d) (emphasis added).

to Mariners.[43] Mariners' certifications are fully supported by the written agreements which set forth the services furnished under each agreement, establish that payments are only for Part A services to Mariners, and make it clear that the physicians are *solely* responsible for billing and receiving payments for the professional services furnished to patients.[44] This is further supported by the later attestations from the physician groups, which restate and confirm the parties' understanding that the payments under the contracts "*exclusively* cover stand-by availability and administrative services furnished to Mariners Hospital."[45]

The Board finds the type of availability and standby services at issue are not physicians' services to patients, but rather are Part A provider services because none of the contracted services at issue were beneficiary specific.[46] Per 42 C.F.R. § 415.102(b), availability and standby services that are *not* "personally furnished for an individual beneficiary" are reimbursed to the provider under Part A because they "are related to beneficiary care furnished by the provider…." Furthermore, 42 C.F.R. § 415.102(b) requires "the intermediary [to] pay[] for those services, if otherwise covered . . . on the basis of reasonable cost or PPS, as appropriate."

Moreover, the Board finds that the payments to Criticare and Anesthesiology Associates for Part A services were reasonable. In making this determination, the Board first reviewed the Fair Market Value ("FMV") analysis prepared by HealthCare Appraisers as well as other information provided related to the Criticare and Anesthesiology Associates contracts.[47] HealthCare Appraisers determined for each contract that the FMV of the contracted services exceeded the contract payments made by Mariners. However, the Board found this study to be of limited value in determining if the costs of these contracts were reasonable, as the FMV analysis was based on numerous unsupported assumptions and representations made by Mariners.

As a result of these concerns, the Board requested additional information to corroborate the FMV analysis and establish that the payments made under the Criticare and Anesthesiology Associates contracts were reasonable. As previously discussed, under these contracts Mariners only paid for Part A services and any Part B services furnished to Mariners' patients were billed separately by the physicians to the patients and/or their third party insurers. In recognition of these facts, the Board requested that Mariners furnish records substantiating the amount of time the physicians servicing the Criticare and Anesthesiology Associates contract spent providing Part A activities for Mariners during FYs 2012 through 2014. With this information, the Board would be able to establish an hourly rate for the contracted Part A services at issue (*i.e.*, total contract payments for Part A services / total hours furnishing Part A services).

Mariners responded to the Board's request on February 15, 2018 providing information that identified physician time spent in Part A activities (*i.e.*, time that was not for direct patient care). In Tab 1 of the February 15th submittal, Mariners calculated that Anesthesiology Associates spent approximately 7,900 hours on Part A activities for Mariners. Additionally at Tab 2,

[43] Provider's Consolidated Final Position Paper at 3-4, 9.
[44] *See* Exhibit P-2 at §§ 5.1, 5.7; Exhibit P-4 at §§ 5.1, 5.7.
[45] Exhibit P-8 (emphasis added).
[46] 42 C.F.R. § 415.102.
[47] Exhibits P-6, P-7.

Mariners calculated that Criticare spent approximately 6,000 to 7,000 hours on Part A activities for Mariners. Based on this information, Mariners determined that the cost of contracted Anesthesiology Associates' Part A services ranged from $107 to $109 dollars an hour while the costs of contracted Criticare's Part A services ranged from $64 to $72 dollars an hour. The Board finds these hourly amounts reasonable when considering the type and amount of services the contractors performed.

Specifically, the Board finds that Anesthesiology Associates provided Part A services to Mariners that included having no less than one Anesthesiologist available on the premise or on call 24 hours per day / 7 days per week, for anesthesia and consulting services; being physically present to assist the technical staff in the Surgical Services department; participating in Mariners' medical management initiatives and clinical performance improvement initiatives; providing medical director services for the Surgical Services department; attending Medical staff meetings as requested; monitoring and evaluating the quality and appropriateness of anesthesia services; providing clinical supervision and training of surgical services staff; *etc*.[48] Based on the range of administrative and availability services provided, the Board does not find the rate of $107 to $109 an hour to be unreasonable based on the type and amount of services the contractors performed and the average salary of anesthesiologists.[49]

Similarly the Board finds that Criticare provided Part A services to Mariners that included having an adequate number of physicians and allied health professionals trained in the specialty of emergency medicine available on the premise or on-call twenty-four hours a day/ seven day a week to provide emergency medical services; providing oversight of emergency medical services; providing medical director services for the emergency department; providing clinical supervision and training of emergency department staff; participating in the Provider's medical management and clinical improvement initiatives; monitoring and evaluating the quality and appropriateness of emergency medical services; etc.[50] Based on the range of administrative and availability services provided, the Board does not find the rate of $64 to $72 an hour to be unreasonable based on the type and amount of services the contractors performed and the average salary of emergency care physicians and other allied health professionals.[51]

In summary, the Board concludes that the payments made for the Anesthesia Associates and Criticare agreements for FYs 2012, 2013, and 2014 are reasonable costs for Part A services to Mariners. Accordingly, the Board remands the cost reports for these fiscal years to the Medicare Contractor to reverse the adjustments that reclassified these payments as Part B services.

---

[48] Exhibit P-4 at 2-3, 8-10.

[49] *See, e.g.*, CMS published reasonable compensation equivalent ("RCE") limits for purposes of illustration bearing in mind that 42 C.F.R. § 413.70(a)(1) sates that, in determining reasonable costs for CAH inpatient services, RCE limits are excluded as an applicable payment principle.

[50] Exhibit P-2 at 3-4, 8-10.

[51] *See, e.g.*, CMS published RCE limits for purposes of illustration bearing in mind that 42 C.F.R. § 413.70(a)(1) sates that, in determining reasonable costs for CAH inpatient services, RCE limits are excluded as an applicable payment principle.

DECISION AND ORDER

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly classified payments made by Mariners for emergency and anesthesiologist service agreements as Part B costs for FYs 2012, 2013, and 2014. Accordingly, the Board remands the cost reports for these fiscal years back to the Medicare Contractor to properly classify the payments made for these services as Part A provider costs.

BOARD MEMBERS PARTICIPATING

Charlotte F. Benson, C.P.A.
Gregory Ziegler, C.P.A, C.P.C-A
Robert Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

3/28/2019

X Gregory H. Ziegler

Gregory Ziegler, C.P.A, C.P.C.- A
Board Member
Signed by: Gregory H. Ziegler -A