

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:

**St. Luke Community Health Care
Provider**

vs.

**Blue Cross BlueShield Association
Intermediary**

Claim for:

**Determination for Cost Reporting
Period Ending: December 31, 2004**

**Review of:
PRRB Dec. No. 2009-D09
Dated: February 25, 2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. CMS' Center for Medicare Management (CMM) also submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Provider is a critical access hospital (CAH) located in Ronan, Montana. For its cost reporting period ending on December 31, 2004, the Provider furnished certified registered nurse anesthetologist (CRNA) services to Medicare beneficiaries through a contract with an

outside supplier. The Intermediary reviewed the CRNA contract and disallowed a portion of the payments made by the Provider that were determined to be for “on-call” services.

ISSUE AND BOARD’S DECISION

The issue is whether the Intermediary’s disallowance of the Provider’s CRNA on-call costs was proper. The Board found that the Intermediary improperly disallowed the standby costs incurred by the Provider for contracted CRNA services. The Board reversed the Intermediary’s disallowance, stating 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, the standby costs met the reasonable cost standards of the regulations and are allowable.

The Board also stated that there is no evidence that it was “longstanding” CMS policy to never allow unspecified standby costs. The Board found support in the statute, regulations and program instructions that the opposite is true, provided that the standby costs were reasonable and necessary.

SUMMARY OF COMMENTS

The Intermediary submitted comments and asserted that the regulation for a CAH only permits standby costs for physicians, physician assistants, nurse practitioners and clinical nurse specialists. The Intermediary argued that standby time is not permitted as a reasonable cost for a CRNA.

CMM submitted comments requesting that the Board’s decision be reversed. CMM stated that the Board improperly allowed the standby costs associated with the CRNA. CMM asserted that CRNA costs included in the Provider’s cost report as “standby cost” are not a cost of services provided and are not allowable as either availability costs or as on-call costs.

The Provider commented, requesting affirmation of the Board’s decision. The Provider stated that the Board correctly found that nothing in the statute and regulations precludes the allowance of standby costs under reasonable cost principles. The Intermediary was incorrect in concluding that reasonable cost principles only allow standby costs in those instances specifically identified in the Medicare program instructions.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.¹

Prior to 1983, Medicare primarily reimbursed providers on a reasonable cost basis. Section 1861(v)(1)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." Section 1861(v)(1)(a) of the Act does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.² Reasonable cost includes all necessary and proper cost incurred in furnishing the services. Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.³ Accordingly, if a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program.

¹The American Hospital Association along with several hospitals, medical centers, professional associations of CRNAs and similarly situated providers submitted comments that support the Provider's contentions and urge the Administrator to affirm the Board's decision.

² See e.g. 42 C.F.R. §413.9.

³Further, the regulation at 42 CFR 412.113(c) provides for reasonable cost payment of anesthesia services provided by a hospital or CAH employed non-physician anesthetists.

In addition to the reasonable cost principles outlined in 42 C.F.R. §413.9 of the regulation, the regulation at 42 C.F.R. §413.70⁴ provides that providers designated as Critical Access Hospitals will be paid reasonable cost for inpatient services furnished to Medicare beneficiaries. These sections of regulation apply in determining reasonable cost for the Provider, however, none of the sections of the regulation identifies CRNA “standby” costs as a reasonable cost.

The statute, regulations and program instructions do not contemplate that normal standby costs are considered reasonable costs. The Board erred in confusing the term “standby” with availability and on-call services. Standby costs are not equivalent to on-call service costs for Medicare purposes. For Medicare purposes, “standby” does not include and is not used interchangeably with physician availability or on-call services. This principle is reflected in the statute at Section 1861(v)(1)(A) of the Act which states the following within the context of establishing implementing regulations on this issue:

Such regulations shall (i) 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 covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary cost of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and ...” (Emphasis added.)

The regulation at 42 C.F.R. §413.9 states that reasonable costs include “normal standby” costs, which indicates that only some standby costs would be allowable. While the term “normal standby” cost is not defined in the regulations, the Provider Reimbursement Manual (PRM) includes several examples of situations in which standby costs are allowable. Section 2102.1 of the PRM indicates that standby costs are defined as those attributable to

⁴ 42 CFR 413.70(a) and (b) respectively state that “payment for” [inpatient and outpatient services] “of a CAH is the reasonable costs of the CAH in providing CAH services ... as determined in accordance with Section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter.” The regulation then sets forth specific exceptions not at issue in this case.

unoccupied beds (depreciation, operation of plant, etc.). In addition, the PRM at §2342 states:

Where the unoccupied beds in a partially certified institution are concentrated in the certified portion, the standby costs attributable to the unoccupied beds (e.g., depreciation, operation of plant, etc.)...

The “standby” costs specifically included by statute are related to the provider’s physical plant or structure and not related to the personnel staffing the hospital. In contrast, costs for “availability” of personnel and costs for personnel to be on-call are only allowable as defined in PRM §2109 and 42 C.F.R. §413.70(b)(4).

The CRNA costs included in the Provider’s cost report as “standby cost” are not a cost of services provided and are not allowable as either “availability” costs or as “on call” costs. PRM §2109.2 defines “availability” as the physical presence of a physician in a hospital. PRM §2109.1 states:

Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section.

The allowance of these costs in emergency rooms was intended for the specific purpose of assuring physician availability in that setting. The costs for availability of personnel other than physicians (such as CRNAs) are not allowable in the emergency room or anywhere else in the hospital.

On-call service costs are allowable only as described in 42 C.F.R. 413.70(b)(4) which states:

Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph(b) of this section may 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, is not otherwise furnishing physician’s services, and is not on call at any other provider or facility.

Effective January 1, 2005, the reasonable costs of a CAH’s outpatient services also can include amounts for reasonable compensation of emergency room physician assistants, nurse practitioners, and clinical nurse specialists who are on call off-site, are not otherwise

furnishing physicians' services, and are not on call at any other provider or facility.⁵ The on call costs for a CAH are recognized only for the CAH's emergency room, and only as described in that section of the regulation. The cost for any other on call personnel not specified in the regulations is not an allowable cost.

In addition, while 42 C.F.R. 412.113(c) provides for reasonable cost reimbursement for non-physician anesthetists, this regulation must be read in context of the general reasonable cost regulations. As the definition of "reasonable costs" does not include the types of costs claimed by the Provider, these standby costs, similarly, cannot be found to be reasonable CRNA costs.

In light of the foregoing, the Administrator finds that the Board's decision was improper. The "standby" costs claimed by the Provider in this case are not attributable to unoccupied beds (depreciation, operation of plant), the physical presence of a physician in the CAH's emergency room, nor the costs for approved non-physician specialists in a CAH's emergency room after January 1, 2005. Accordingly, the Administrator reverses the Board's decision in this case.

⁵ See, 42 C.F.R. 413.70(b)(4).

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE
SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: 4/23/2009

/s/

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services