

**PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION**

ON THE RECORD
2002-D19

PROVIDER –
Bonner General Hospital
Sandpoint, Idaho

Provider No. 13-0024

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Medicare Northwest

DATE OF HEARING-
March 1, 2002

Cost Reporting Period Ended –
August 31, 1996

CASE NO. 99-0233

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ISSUE:

Was the Intermediary's adjustment to emergency room ("ER") physicians' availability costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bonner General Hospital (the "Provider") operates a 62-bed acute care hospital, home health agency and hospice in Sandpoint, Idaho. The Provider is classified as a sole community hospital due to its rural location and distance from the next closest acute care hospital. On its fiscal year ended ("FYE") August 31, 1996 cost report, the Provider claimed reimbursement for ER physician availability costs. Blue Cross and Blue Shield of Oregon (the "Intermediary") made an adjustment to the cost report that eliminated the ER physician availability costs.¹ The Provider filed a timely appeal and has met the jurisdictional requirements set forth in 42 C.F.R. § 405.1835-1841. The Medicare reimbursement in controversy is approximately \$27,336.

The Provider Reimbursement Manual, Part 1 ("CMS Pub. 15-1") § 2109.1 et seq. provides for the reimbursement of hospital emergency department services when physicians receive compensation for availability services. It states that:

[w]ide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an availability status awaiting the arrival of patients. Alternatively, hospitals may need to arrange for emergency department physician coverage for evenings, weekends or holidays, when staff or community physicians are not available. Since these periods frequently generate inadequate physician revenue through charges for professional services due to lower utilization, hospitals may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments.

When emergency department physicians are compensated on an hourly or salary basis or under a minimum guarantee arrangement (§2109.2E), providers may include a reasonable amount in allowable costs for emergency department physician availability

¹ See Provider Exhibit 2 and Intermediary Exhibit 1.

services subject to limitation through the application of Reasonable Compensation Equivalents (RCEs). Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section.

CMS Pub. 15-1 § 2109.1.

CMS Pub. 15-1 § 2109.4 provides for two methods for determining allowable emergency physician availability services costs. It states that:

[w]hen a provider compensates emergency physicians for being available to render physician services to individual patients in the emergency department, the provider may be reimbursed Medicare's share of the allowable costs incurred by the provider to the extent that the costs are determined reasonable. Provider reimbursement will be based on the lesser of the actual compensation paid to the physician or the reasonable compensation determined through the application of the RCE limits to the hours of emergency department availability stipulated in the approved provider/physician allocation agreement. If the required allocation agreement does not specify the availability services hours for which the provider compensates the physician, availability service costs will not be allowable unless the conditions of §2109.4C are met with respect to minimum guarantee arrangements.

CMS Pub 15-1 § 2109.4.A.

The Provider noted that it had received reimbursement for emergency physician availability service costs in previous fiscal years. The Provider submitted copies of its "model" contract with physicians for ER coverage in which they are reimbursed on an hourly basis.² The specific language in the contract is in paragraph 12 which states:

For his/her services the Physician shall receive the sum of SIXTY DOLLARS (\$60.00) per hour, as a guarantee and will increase to SEVENTY DOLLARS (\$70.00) per hour for the entire 24 hour shift should the census exceed 50 patients for the 24 hour shift, or

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See Provider Exhibit 7.

for the 12 hour shift should the census exceed 25 patients for the 12 hour shift. The Physician understands that no part of the Hospital's billings to the patient shall be paid to him/her, nor will he/she receive supplemental compensation from the Hospital from any other source.³

³

Id. at 3.

The Provider's original computation of the allowable emergency room availability costs was included in Worksheet A-8-2 of the originally filed Medicare cost report.⁴

The Provider had ER physician charges of \$540,076 and ER Physician compensation of \$527,040. Of the total Part A compensation, the Provider identified and claimed \$218,640 as availability costs in the as-filed cost report. The Intermediary determined that there was no physician availability situation and disallowed that amount by treating it as Part B compensation in adjustment 10.⁵

The Provider was represented by Thomas D. Dingus, CPA, of LeMaster and Daniels, PLLC. The Intermediary was represented by Danilo V. Tabang, Consultant, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it continued to qualify for Medicare reimbursement for ER physician availability costs during the fiscal year ended August 31, 1996. The Provider believes that the Intermediary has misinterpreted and misapplied the CMS Pub. 15-1 § 2109 *et seq.*, "Reimbursement of Hospital Emergency Department Services When Physicians Receive Compensation for Availability Services." Specifically, CMS Pub. 15-1 § 2109.4, "Methodology for Determining Allowable Emergency Physician Availability Services Costs." This section, which describes the two methods in which reimbursable emergency room availability costs can be computed, addresses the disputed issue.

The Provider notes that one method is "Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements." This method considers ER physician gross charges, but this is not the method under which the Provider is seeking reimbursement for its ER physician availability services.

⁴ See Provider Exhibit 5 and Provider Exhibit 6, HCFA Form 339, Exhibit 3A, "Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements: Computation."

⁵ See Intermediary Exhibit 1.

The other method is “Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements.” The Provider presented an example of its Provider contract.⁶ The Provider uses a “model” contract for its ER physicians. The example contract demonstrates that the Provider compensates its ER physicians on an hourly basis. As described and illustrated in CMS Pub. 15-1 § 2109.4.B, the Provider “will be reimbursed Medicare’s share of incurred physician availability services costs subject to the RCE limitation.” Nowhere in this description and illustration are gross charges referred to as a limiting factor for Medicare reimbursement of ER physician availability costs.

The Intermediary contends in its position paper that the Provider is attempting to claim double reimbursement from Medicare for the same services. The Provider is not attempting to claim double reimbursement. The Provider receives reimbursement from the Part B Carrier (and other payors) when the emergency room physicians are providing services to patients. The ER physicians are paid an hourly rate to provide these services. The Provider bills and collects from the Part B Carrier and other payors. The Provider is then seeking reimbursement from Part A for the cost of making emergency room services available to the public. The Provider maintains time records that document when ER services are being provided and when there are not ER services being provided. The Provider ER physicians are paid an hourly rate to be available (and onsite) regardless of patient volume. This “availability” cost is an allowable Part A cost under the Medicare program. It is Medicare’s intent to reimburse rural hospitals for emergency room availability time in order to make ER services available in rural areas. It is not financially feasible to have 24-hour a day ER coverage in rural areas because of low patient volumes and the limited amount of qualified physicians to provide ER services. Without 24-hour a day ER coverage, access to ER services would be unavailable to Medicare patients and lives would be lost.

The Provider’s original computation of the allowable emergency room availability costs was included in Worksheet A-8-2 of the originally filed Medicare cost report.⁷

⁶ See Provider Exhibit 7.

⁷ See Provider Exhibit 5 and Provider Exhibit 6, Exhibit 3A, “Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements: Computation” of the originally filed HCFA Form 339.

The Intermediary states in its position paper that “[t]he Provider did not furnish sufficient information or documentation, either during the audit or through its position paper, to support its contentions. It did not demonstrate with compelling or convincing evidence that the amount of \$218,640 actually relates to availability services.” The Provider asserts that the \$218,640 of availability costs was not questioned by the Intermediary during the audit. The Provider was not aware of this issue until the Intermediary’s position paper was received, which was four days before the final position paper was due. The issue disputed by the Intermediary during the audit was the application of “Allowable Availability Service Costs Under Hourly Rate or Salary Arrangements” versus “Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements.” The Provider does not understand why this issue has been included in the Intermediary’s position paper since it would be a moot point if their position that this ER physician coverage situation was an "Unmet Guarantee" was correct. It appears to be the Intermediary’s “back-up” plan for disallowing the ER physician availability costs. The Provider’s methodology to calculate ER physician availability costs was audited by the Intermediary in years prior to fiscal year ended August 31, 1996, and found to be an allowable, supportable, and documented methodology. Neither the Provider’s methodology nor the relevant law changed in fiscal year ended August 31, 1996. In short, the Provider has not provided the evidence supporting the ER availability service costs because it was not the issue disputed by the Intermediary during the audit and the evidence was not requested during the Intermediary’s audit.

Also, CMS Pub. 15-1 § 2109.3, “Allowability of Emergency Department Physician Availability Services Costs,” specifically addresses the special circumstances in which ER physician availability costs will be allowable. The Provider meets the stated special circumstances and these circumstances are not disputed by the Intermediary.

INTERMEDIARY’S CONTENTIONS:

The Intermediary argues that the Provider did not submit sufficient information and documentation to support its contention that it incurred physician availability services. The Intermediary also argues that the Provider contract should be treated as a minimum guarantee arrangement (“MGA”) and that as a MGA there is no unmet guarantee amount.

The Intermediary indicates that the Provider’s records or books reflected the ER physicians’ charges of \$540,076 and ER physicians’ compensation of \$527,040. Of the total Part A compensation, the Provider identified and claimed the amount of \$218,640 as availability costs in the as-filed cost report. The Intermediary, after determining that there is no physician availability situation, disallowed that amount by treating it as Part B compensation in adjustment number 10.⁸

Based on a review of the Provider’s position paper, the Intermediary concludes that the Provider

⁸ See Intermediary Exhibit 1.

is contending that, since the ER physicians were paid an hourly rate, all costs that relate to the time the physicians were not with patients are physician availability service costs.

The Intermediary contends that the Provider did not prepare its position paper in accordance with 42 C.F.R. § 405.1853 and CMS Pub. 15-1 § 2921.5 because the Provider did not state adequate facts and contentions, cite all appropriate controlling authorities and furnish any documentary evidence, pursuant to the referenced program regulation and instruction. The Board should consider the following provisions of CMS Pub. 15-1 § 2921.5:

If the provider's submittal does not explain the facts or make any arguments about an issue, the Board may find that the position paper submitted for that issue is not acceptable and may dismiss that issue from an appeal. Similarly, if a provider's submittal of a position paper does not explain the facts or make arguments about any issues, the entire appeal may be dismissed by the Board.

The Intermediary contends that the Provider did not furnish sufficient information or documentation, pursuant to 42 C.F.R. § 413.20 and 42 C.F.R. § 413.24, and CMS Pub. 15-1 §§ 2300, 2304 et seq. and 2404.2, either during the audit or through its position paper, to support its contentions. It did not demonstrate with compelling or convincing evidence that the amount of \$218,640 actually relates to availability services. The Provider generated document did not explain what the 3,644 “Non-productive Time (Provider Component)” hours meant.⁹ Also, the Provider did not demonstrate that the “Independent Contractor Agreement for Emergency Services” covers availability services or relates to a minimum guarantee contract.¹⁰

The Intermediary asserts that the Provider is not in compliance with its record keeping requirement. It has the responsibility to demonstrate and support the issue that it is disputing specifically if it affects payment. The referenced regulations and instructions explicitly require that the Provider maintain sufficient financial records and statistical data for proper determination of costs payable. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited and in sufficient detail to accomplish the intended purpose.

The Intermediary contends that it made its determination in accordance with CMS Pub. 15-1 § 2109 et seq. that the related ER room physician agreement is a minimum guarantee arrangement and does not cover availability services as the Provider purported. It has also properly made a determination, using the illustration shown in CMS Pub. 15-1 § 2109.4.C, not § 2109.4.B, that no unmet guarantee situation existed and no availability service costs are allowable.

⁹ See Intermediary Exhibit 1.

¹⁰ See Intermediary Exhibit 2.

The Intermediary concluded, based on its review of the documentation furnished by the Provider, pursuant to CMS Pub. 15-1 § 2109.3.C, that the ER contract does not specify any availability service hours.¹¹ Also, a minimum guarantee arrangement existed based on paragraph 12 of the contract, which states as follows:

12. For his/her services the Physician shall receive the sum of SIXTY DOLLARS (\$60.00) per hour, **as a guarantee and will increase** to SEVENTY DOLLARS (\$70.00) per hour for the entire 24 hour shift **should the census exceed 50 patients for the 24 hour shift**, or for the 12 hour shift **should the census exceed 25 patients for the 12 hour shift**. The Physician understands that no part of the Hospital's billings to the patient shall be paid to him/her, nor will he/she receive supplemental compensation from the Hospital from any other source.

(Emphasis added.)

While the Intermediary acknowledges that the ER physician was paid an hourly rate, it contends that fact alone does not preclude the contract from falling under the definition of a minimum guarantee arrangement. The Intermediary therefore followed the provision of CMS Pub. 15-1 § 2109.4.C in determining the availability service costs. However, since the charges exceeded the related costs, the Intermediary determined that no unmet guarantee had occurred. Accordingly, in view of that determination, and since the Provider did not demonstrate the allowability of the claimed availability service costs, the Intermediary disallowed the related amount.

The Intermediary claims its determination is in accordance with CMS Pub. 15-1 § 2109.2, which states in part as follows:

A. Physician Availability Services.—Physician availability services consist of the physical presence of a physician in a hospital under a formal arrangement with the hospital to render emergency treatment to individual patients as and when needed.

B. Reasonable Compensation.—A Reasonable Compensation Equivalent (RCE) is the limitation on the cost which a provider can claim for compensation of services furnished by physicians to providers . . .

C. RCE Base.—The RCE base is the physician compensation amount that the program will recognize for provider services and availability services, whether compensation for availability services is calculated under an hourly rate or salary arrangement, or based on a minimum guarantee amount calculated for a specified number of direct patient care

¹¹ See Intermediary Exhibit 2.

service hours under a minimum guarantee arrangement

...

E. Minimum Guarantee Arrangement.—A minimum guarantee arrangement is a financial arrangement between a physician or a group of physicians and a provider where the physician(s) is (are) guaranteed a minimum level of compensation (the minimum guarantee) for availability services. The physician(s) may receive more than the minimum amount guaranteed if they generate charges for services to individual patients in excess of the minimum guarantee amount. If the charges fall short of the minimum guarantee amount, the provider is obligated to pay the physician(s) for the difference to make up the guaranteed amount. A minimum guarantee arrangement may also contain provisions for compensating physicians for performing provider services such as supervision of the emergency department, administration, etc.

F. Unmet Guarantee Amount.--An unmet guarantee amount is the amount by which the minimum guarantee amount exceeds total physician charges for services to individual patients during the cost reporting period. Total physician charges include imputed charges for services performed but not billed. Total physician charges, not collections, must be included in the computation.

(Emphasis added)

Also, the Intermediary points to the following language for support.

A. General. --When a provider compensates emergency physicians for being available to render physician services to individual patients in the emergency department, the provider may be reimbursed Medicare's share of the allowable costs incurred by the provider to the extent that the costs are determined reasonable. Provider reimbursement will be based on the lesser of the actual compensation paid to the physician or the reasonable compensation determined through the application of the RCE limits to the hours of emergency department availability stipulated in the approved provider/physician allocation agreement. If the required allocation agreement does not specify the availability services hours for which the provider compensates the physician, availability services costs will not be allowable unless the conditions of §2109.4C are met with respect to minimum guarantee arrangements.

...

C. Allowable Unmet Guarantee Amounts Under Minimum Guarantee Arrangements.—The allowable cost of an unmet guarantee is determined by subtracting total charges for physician charges for physician services to individual patients from the lesser of (1) the minimum guarantee amount specified in the provider/physician arrangement or (2) the reasonable compensation amount which is arrived at by applying the RCE limits (as

adjusted for any appropriate additional allowances) to the physician's total hours allocated for individual patient care.

CMS Pub. 15-1 § 2109.4. (Emphasis added.)

The Intermediary did not make its determination under CMS Pub. 15-1 § 2109.4.B, because the ER physician contract did not have any provision regarding availability services and the allocation agreement showed questionable information regarding the availability hours which the Provider identified as “Non-productive time (Provider Component).” Also, it applies to situations where no minimum guarantee is arranged, which is not the case here.

The mere fact that the Provider has compensated the physicians on an hourly basis does not create an availability service arrangement situation. The illustration in this instruction shows a calculation of availability service costs based on the specified availability hours. There was no minimum guaranteed amount in that illustration; thus, there was no necessity of comparing the total charges to the allowable costs. As illustrated, the computation is only addressing the allowable costs that are above and beyond the billed charges amounts that are on the Provider's books. This computation is consistent with CMS Pub. 15-1 § 2109.1, which used the phrases such as “commensurate with the actual volume of services,” “inadequate physician revenue,” and “supplemental compensation.” Again, the Intermediary believes that Medicare intends to reimburse the unrecovered costs only that are above and beyond the billed charge amount.

It appears that the Provider is attempting to claim double reimbursement from Medicare for the same services. The Provider has already been reimbursed its Medicare share of the \$540,076 for physician charges from fees billed to Part B Carrier. The Provider is again claiming Medicare reimbursement for \$218,640 that does not appear to be physician availability services as defined in CMS Pub. 15-1 § 2109.2.A from the Part A Intermediary.

Furthermore, CMS Pub. 15-1 § 2109 et seq. addresses the costs that are above and beyond the billed physician charges. The instructions do not address a situation where the physician compensation is less than the billed physician charges such as in the Provider's case. Also, it is not apparent how the Provider came up with availability service costs of \$218,640 since it did not identify and support the physician availability service hours. As shown in a Provider-generated document, the Provider estimated the claimed amount based on the amount of time that the ER physicians are not with patients.¹²

Contracting ER services on the basis of hourly rate is common practice in the industry. However, Medicare does not intend to pay for costs when the compensation does not exceed the billed charges; otherwise, it would have shown a separate illustration in that regard in addition to the two illustrations in CMS Pub. 15-1 § 2109.4.B and C. Also, unless the Provider demonstrates that the time relates to allowable Part A or hospital services, Medicare does not pay

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See Intermediary Exhibit 3.

for the physician's time not spent with patients. Using the Provider's logic would mean that the only time Medicare would not be paying for availability services is if the ER physician is with patients 100 percent of the time. The Intermediary contends that 100 percent ER physician contact with patients does not exist, and that it is the intent of the Medicare program to only reimburse the unrecovered cost of compensation exceeding billed charges as availability costs.

As shown, the physicians had been fully reimbursed for Medicare physician fees by the Part B Carrier and the Provider has not demonstrated with compelling or convincing evidence that it is entitled to Program payment for any availability service costs as Part A costs.

The Intermediary contends that the Board should uphold the referenced regulations and instructions that supported the determination or adjustment, pursuant to 42 U.S.C. § 1395oo, 42 C.F.R. § 405.1867 and CMS Pub. 15-1 § 2924.6.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:
 - § 1395oo - Provider Reimbursement Review Board.

2. Regulations - 42 C.F.R.:
 - § 405.1835-.1841 - Board Jurisdiction
 - § 405.1853 - Prehearing Discovery and Other Proceedings Prior to the Board Hearing
 - § 405.1867 - Sources of Board's Authority
 - § 413.20 - Financial Data and Reports.
 - § 413.24 - Adequate Cost Data and Cost Finding.

3. Program Instructions - Provider Reimbursement Manual, Part I (CMS Pub. 15-1):
 - § 2109 - Reimbursement of Hospital Emergency Department Services When Physicians Receive Compensation for Availability Services.
 - § 2109.1 - General.
 - § 2109.2 - Definitions.
 - § 2109.3 - Allowability of Emergency Department Physician

Availability Service Costs

- § 2109.4 et seq. - Methodology for Determining Allowable Emergency Physician Availability Service Costs.
 - § 2300 - Adequate Cost Data and Cost Finding: Principle.
 - § 2304 - Adequacy of Cost Information.
 - § 2304.1 - Availability of Records of Providers.
 - § 2404.2 - Examination of Pertinent Data and Information.
 - § 2921.5 - Position Papers.
 - § 2924.6 - Scope of Board's Authority.
5. Other:

Provider Cost Report Reimbursement Questionnaire Form HCFA - 339 (11/95)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions and evidence presented, finds and concludes as follows:

The Board finds that the issue in this appeal is covered by CMS Pub. 15-1 § 2109.3.

The Board further finds that the Provider submitted adequate documentation that its physicians spend a portion of their time in an availability status awaiting the arrival of patients. The Provider submitted the reasonable compensation determination through application of the RCE limits to the emergency department availability stipulated in the approved provider/physician allocation agreement. The Board does not consider the physician contract to be a minimum guarantee arrangement and concurs that the Provider's ER availability costs should be determined under the hourly or salary methodology. CMS Pub. 15-1 § 2109.4B.

The Board notes that the Provider is classified as a sole community hospital due to its location in a rural area and distance from the next closest acute care hospital and that it had qualified for Medicare reimbursement for ER physician availability costs in previous fiscal years before the year at issue in the instant case. The Provider presented the Intermediary with documentation concerning the time spent by physicians in their ER.¹³ From that documentation, the Intermediary was able to determine the total amount of time spent in management, direct patient

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See Intermediary Exhibit 1, note at bottom of the page.

care, non-productive activities (defined as the log of time when no patients were present in ER) and the total amount of available time. The Board notes that the total available time was 9,116 hours and that the amount of non-productive time was 3,644 hours.¹⁴ Based on these figures, the Provider's ER physicians spent 40 percent of their time awaiting patients. The Board finds that this data supports the Provider claim that ER physicians are spending a substantial portion of their time in an available status awaiting the arrival of patients and that it should receive compensation under CMS Pub. 15-1 2109 et seq.

¹⁴Id. at 2.

The Board further notes that this information was utilized by the Provider in filling out the allocation agreement in FORM HCFA-339, Exhibit 3 - Hospital Emergency Department Under Hourly Rate: Data Elements and Exhibit 3A - Hospital Emergency Department Provider-Based Physician Allowable Availability Service Costs Under Hourly Rate or Salary Arrangement.¹⁵ The Provider's claim that FORM 339 was supported by the appropriate time study was not contested. The Board finds that the Provider submitted the reasonable compensation determination through application of the RCE limits to the emergency department availability stipulated in this approved provider/physician allocation agreement.

The Board notes that the Intermediary did not determine the physician availability costs under the hourly method because it interpreted the contract between the Provider and physicians as a minimum guarantee contract. The Provider contract with its ER physicians provides for an hourly wage of \$60 and an increase to \$70 during periods of higher ER utilization.¹⁶ The ER physicians only received an hourly wage, and the contract specifically indicated that "no part of the Hospital's billing to the patient shall be paid to him/her, nor will he/she receive supplemental compensation from the Hospital from any other source."¹⁷ The Board does not believe that the Provider created a minimum guarantee contract simply because it used the word "guarantee" in the contract in association with its description of the lower of the two hourly wages to be paid. The Board finds that the Provider's costs should be determined under CMS Pub. 15-1 § 2109.4.B, which addresses the determination of allowable availability service costs under an hourly rate or salary arrangement. The Board notes that the Provider properly calculated its costs under the hourly method in its as filed cost report and that total patient charges are not considered in that calculation.¹⁸

Since the Provider performed all of the billing for the ER services, the Board finds no requirement in the policy manual requiring that charges be taken into account.

In its analysis, the Board reviewed the documentation policy under CMS Pub. 15-1 § 2109.3. The Board notes that the Provider supplied items 1, 2 and 4. Items 3 and 5 were not contested by the Intermediary. Items 6 and 7 do not apply to this appeal. The Board also notes that for item 7, the policy manual at § 2109.3A states that "[i]t is not necessary for a provider to demonstrate that it explored alternative methods for obtaining emergency physician coverage annually."

In summary, the Board finds that the Provider submitted proper documentation to have its ER physician availability hours determined under the hourly rate subject to the RCE limitation.

¹⁵ See Provider Exhibit 6.

¹⁶ See Provider Exhibit 7, Paragraph 12.

¹⁷ Id.

¹⁸ See Provider Exhibit 6.

DECISION AND ORDER:

The Intermediary's adjustment disallowing ER physician availability costs was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: May 16, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman

My conservative nature demands a dissent.

Any Appeal appearing before the PRRB belongs to the Provider. The Provider bears the burden of proof, one of presenting adequate documentation and significant evidentiary weight to convince the Board to overturn the Intermediary's adjustment on the Provider's Cost Report. 42 C.F.R. § 413.20 and § 413.24 speak to these basic requirements. In addition, CMS Pub. 15-1 § 2925.7 clarifies the fact that in a Hearing-on-the-Record, the PRRB is limited to the written evidence before it as presented by both parties. Based on the above regulations, unless I follow the "assumption path" of the Majority, I can not find adequate documentation within the record itself to reverse the Intermediary reversal of the Provider's request for "availability costs" for its ER physicians.

It is first critical to note that in order to even be eligible for "availability cost" Medicare payments, the Provider must show a computation that includes the essential components detailing reasonable cost (calculation based on the lesser of actual compensation paid the physician or reasonable compensation determined through application of the RCE limits to the hours of availability [NOTE: not based on the NON-available hours] stipulated in an approved provider/physician allocation agreement (§ 2109.4.A); with the underlying concept being that Medicare is willing to pay its fair share of such costs "Since these periods [awaiting the arrival of patients] frequently generate inadequate physician revenue [and] . . . due to lower utilization, hospitals may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments." (§ 2109.1) None of the four (4) essential elements - demonstration of reasonable cost, a Medicare allocation agreement, documentation of low utilization, nor a suggestion that the requested "availability cost" payment from Medicare was to be used as physician "supplemental compensation" are evident in the Provider's Position Paper or Exhibits.

There are three (3) bases mentioned in CMS Pub. 15-1 §2109.1 whereby a hospital might be eligible for Medicare payment for "availability time" costs of ER physicians. The three (3) bases that serve as the calculational determinants for ascertaining eligibility for Medicare payment for "availability costs" revolve around identification of the mode of physician payment: hourly, salary, or minimum guarantee arrangement. Each basis demands, at the very least, a determination of a reasonable amount of allowable Medicare cost "subject to limitation through the application of Reasonable Compensation Equivalents (RCE's)." §

2109.1 The Provider's documentation, in my opinion, does not even come close to this benchmark. The closest analogy to the Provider's methodology for documenting "availability costs" that I can conjure would be to go out and identify a business or industry that has both federal contract and non-federal components, add up all of the time all employees, both federal-contract and non-contract, spend on coffee breaks throughout the year, multiply that by the average hourly salary of all employees, and then pay the employer a bonus for this "non-productive" time, regardless of revenue and any question of productivity or whether or not the employer has already covered total employee costs via adequate income. No documentation relevant to reasonable cost or productivity is required, simply add up the time for coffee breaks, multiply times the average hourly salary, and pay the entity a bonus for downtime.

In the instant case, there is a paucity of evidence and documentation regarding the critical ER "availability cost" elements of reasonable cost, allocation agreement, low utilization, and supplemental income. Based solely on the record before us, I submit it is impossible to find for the Provider.

The Majority is willing to accept the Employment Contract (Provider Exhibit 7) as the critical Medicare "allocation agreement". In their collective opinion, this negates the need for virtually all other documentation. In my opinion, the Employment Contract is just that - an Employment Contract, nothing less, nothing more. There is not to be found, within the four corners of that document, any reference to Medicare allocation, or to the documentation requirements of § 2109.3.C. Clearly, these documentation requirements apply to any and all requests for Emergency Department Physician Availability Services Costs stemming from § 2109.3, regardless of hospital location or designation. As stated in § 2109.3, "... costs will be allowable only in special circumstances, as follows . . ."

The documentation required in § 2109.3.C contains seven (7) elements. Only one (1), a signed copy of the contract between the hospital and the physician(s) is presented as evidence in the instant case. The other six (6) critical elements are absent. Absent from the record are 1) the written Medicare allocation agreement; 2) a permanent record of payments to physicians (actually, the record did include a summary statement indicating that the Provider had apparently been compensated \$527,040 for physician costs and had charges of \$540,076. The Provider is now contending that, based on hours where there were no patients in the ER, they are entitled to an additional "availability cost" that equates to those "non productive" hours times the contractual hourly amount for physicians, totaling \$218,640. This despite the fact that it appears the Provider has already been compensated, both through Medicare and non-Medicare, with funding adequate to cover the ER physician costs.); 3) a record of the amount of time the physician was physically present on hospital premises (again, there was a single-page entry, purportedly taken from the Intermediary work papers, and an "alluding to" document in Provider Exhibit 6, all unsigned, relevant to physician time, but each of these pages contains the notation "SEE ACCOMPANYING ACCOUNTANTS' COMPILATION REPORT", which were not present. Based apparently on this data, the Intermediary reconstructed the "no patient"

hours and the Provider used this negative number as justification for the “availability costs” request, upon which both the Provider and the Majority rely as the basis for relief (the coffee break analogy); 4) a permanent record of all patients (Medicare and non-Medicare) treated, copies of the physicians bills, record of imputed charges; 5) schedule of physician charges, and, 6) evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services (the Medicare prudent buyer concept - there is no evidence in the Record to indicate that the Provider has ever performed this required step). Absent documentation in the Record on these critical elements, it is impossible to determine whether or not the provider’s request demonstrates the most reasonable cost for Medicare on “availability costs” for the ER physicians at Bonner Hospital due to low utilization. The implication presented, both by the Provider and the Intermediary, that ER income exceeded physician cost, and has already been paid, would suggest otherwise.

Henry C. Wessman, Esq.
Senior PRRB Member