

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D10

PROVIDER -
St. Benedicts Family Medical Center
Jerome, Idaho

Provider No.: 13-0029

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Medicare Northwest

DATE OF HEARING -
December 9, 2005

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 04-0209

INDEX

	Page No.
Issue.....	2
Medicare Statutory and Regulatory Background.....	2
Statement of the Case and Procedural History.....	4
Parties' Contentions.....	5
Findings of Fact, Conclusions of Law and Discussion.....	6
Decision and Order.....	7

ISSUE:

Whether the Intermediary was correct in its determination that no costs for physician assistant emergency room availability are allowable as Medicare Part A reimbursable expenses.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. U.S.C. §1395oo; 42 C.F.R. §405.1835.

Medicare reimbursement is governed by section 42 U.S.C. §1395x(v)(1)(A) of the Social Security Act. In part, the statute provides that the "reasonable cost" of any service shall be the cost actually incurred excluding therefrom 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 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services. Moreover, the regulation defines necessary and proper costs as "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider's activity."

Regulations at 42 C.F.R. §§415.50-415.70 provide for program payments to be made for the cost of physician services to providers as opposed to the services they furnish rendering care to patients. In part, the regulations define physician compensation costs and explain that providers that incur such costs must allocate them in proportion to the percentage of total time that is spent furnishing each category of service, i.e., physician services to the provider, physician services to patients, and time spent performing activities such as funded research that are not paid under either Medicare Part A or Part B.

With respect to physician services to providers, program instructions in Medicare's Provider Reimbursement Manual (PRM), Part I (CMS Pub. 15-1) §2109.1 explain that hospitals may have to reimburse physicians to be "available" in their emergency departments because patient revenues may not be sufficient to maintain adequate physician staffing. In part, the manual states:

[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 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.

And finally, 42 C.F.R. §415.60(f) provides the requirements for the payment of physician compensation costs for provider services. The regulation states:

Determination and payment of allowable physician compensation costs. (1) Except as provided under paragraph (e) of this section, the intermediary pays the provider for these costs only if—

(i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends

in furnishing physician services to the provider, physician services to patients, and services that are not payable under either Part A or Part B of Medicare; and

(ii) The compensation is reasonable in terms of the time devoted to these services.

(2) 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. (Emphasis added.)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Benedicts Family Medical Center (Provider) is a non-profit, 24-bed, acute care hospital located in Jerome, Idaho. On July 8, 2002, the Provider requested that Medicare Northwest (Intermediary) reopen its cost report for the fiscal year ended June 30, 2000. The Provider specifically requested that the Intermediary include physicians' availability costs in its cost report for the payments it made under a contract for emergency room coverage furnished by physician assistants.¹ In response, the Intermediary requested additional documentation from the Provider pertaining to this matter, and ultimately, on May 9, 2003, issued a letter to the Provider denying its request.²

The Provider appealed the Intermediary's denial to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately \$23,000.³

The Provider was represented by Michael R. Bell, CPA, of Michael R. Bell & Company. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

¹ The Intermediary argues on page 7 of its position paper that physician assistants are not, categorically, physicians and, therefore, no emergency room availability costs are reimbursable in this case. However, with respect only to this case, the Intermediary withdrew this argument to focus on what it believes are more relevant factors. Therefore, as requested by the Intermediary, the Board (in this particular case) recognizes physician assistants and physicians as conceptual equivalents and may use those terms interchangeably herein. Transcript (Tr.) at 16, 41, and 85-86.

² Intermediary's Position Paper at 5. Provider's Position Paper at Addendum II.

³ Intermediary's Position Paper at 4. Exhibit P-1.

PARTIES' CONTENTIONS:

The Intermediary contends that the Provider did not provide sufficient evidence that it qualifies for an allocation of its physician compensation costs for “emergency room availability services” to the provider as opposed to physician services to patients. The Provider did not submit a written allocation agreement as required by 42 C.F.R. §415.60(f); therefore, 100 percent of the physicians’ compensation costs must be allocated to patient care services.

The Intermediary contends that the Provider did not comply with the documentation requirements of CMS Pub. 15-1 §§2109.3.A and C.7. No credible evidence was offered to demonstrate that alternative methods of obtaining physician coverage were explored, however unsuccessfully, before claiming emergency room physician availability costs. The only documentation submitted by the Provider regarding this matter was a letter signed by its administrator explaining how the facility’s emergency room coverage had evolved subsequent to the year in question (Exhibit I-6).

The Intermediary also contends that even if the Provider had met the program’s documentation requirements, emergency room availability costs would still not be reimbursable.⁴ Pursuant to CMS Pub. 15-1 §2109.4, the methodology for determining the amount of physician emergency room availability costs to be reimbursed by the program is based on one of two methodologies; that is, where there is an agreement between the Provider and the emergency physicians specifying that payment will be made on an hourly rate or salary basis for availability services or, where there is no allocation agreement, under an unmet guarantee arrangement. With respect to the instant case, the Provider acquired emergency room and urgent care medical services through a fixed, contractual, compensation arrangement requiring the Provider to pay an annual amount of \$346,560 as full consideration for the professional services performed under the agreement to include both provider services and direct patient care services. The Intermediary contends that in the absence of a written allocation agreement, the regulations and program instructions require the Provider’s availability service costs to be allocated 100 percent to professional patient care services and reimbursed pursuant to CMS Pub. 15-1 §2109.4.C. entitled Allowable Unmet Guarantee Amounts under Minimum Guarantee Arrangements. Under this manual provision, the amount of physician compensation costs in excess of billed physician availability service charges would be allowable. However, in this case, the Provider billed \$414,529 for professional physician services which exceeds the \$390,238 the Provider actually paid in physician compensation.

The Provider contends that its contract with Emergency Medicine Physician Assistants, P.A. and the documentation submitted with its Medicare cost report, which shows the allocation of the physicians’ assistants’ time between patient care services and emergency room availability, meets the program requirement of 42 C.F.R. §415.60(f) for the submission of a written allocation agreement.⁵ The Provider argues that the contract clearly indicates that all of the time the Provider is paying for is emergency room availability, and auditable emergency room patient logs show exactly how much time was spent with patients.

⁴ Intermediary’s Position Paper at 15. Tr. at 17.

⁵ Tr. at 52. Exhibits I-7 and P-2.

The Provider contends that it also complied with the program's requirement that alternative methods of obtaining physician coverage be explored before claiming emergency room physician availability costs.⁶ The Provider explains its understanding of the purpose of this program requirement is to help assure that emergency room coverage costs are not excessive. The Provider asserts that its use of physician assistants rather than physicians to provide this coverage is a clear indication that it considered all options and elected to use the least expensive option available. The Provider cites to a letter written by its administrator indicating that the hospital had gone through a bidding process in November 2001 for moving its emergency room coverage from a "physician assistant model" to "a physician model," and that each of those bids would have dramatically increased the Provider's emergency room costs.⁷

Finally, the Provider contends that the physicians' assistants are hired basically at an hourly rate, to provide whatever care is needed, as evidenced by the fact that there is no distinction made between the time spent by physicians' assistants providing patient care services as opposed to time spent in availability status.⁸

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly denied the Provider's request to have emergency room physicians' availability costs included in its cost report.

The Board is bound by program regulations, and 42 C.F.R. §415.60(f)(1) is absolutely clear. In order for a provider to be reimbursed for physician compensation costs under Medicare Part A, it must submit a written allocation agreement between the provider and the physician(s) that specifies the respective amounts of time the physician(s) will spend furnishing services to the provider, to patient and other activities not payable under either Part A or Part B of Medicare. The Board finds that the Provider did not submit an allocation agreement that meets the regulatory requirements.

The Board finds erroneous the Provider's position that its contract with the physicians' assistants, along with documentation submitted with its cost report meets the program's requirement for the submission of an allocation agreement. The Provider's contract does not address or otherwise distinguish availability time from the contractor's indisputable responsibility to provide direct patient care (Exhibit I-7). Moreover, the only document submitted with the Provider's cost report that addresses physician time is Exhibit 2 of the Provider Cost Report Reimbursement Questionnaire (HCFA 339) (Exhibit I-5). Notably, the questionnaire allocates 100 percent of physician time to professional services reimbursed under Medicare Part B, with no time allocated to Medicare Part A provider services.⁹ Additionally, the

⁶ Tr. at 60.

⁷ Exhibit P-2 at 11.

⁸ Tr. at 56.

⁹ The record indicates that the Provider showed the same 100 percent allocation of physician time to professional patient care services on Worksheet A-8-2 of its Medicare cost report. Intermediary Position Paper at 9.

questionnaire is signed by the Director of Nursing, as a representative of the hospital, but not signed by a physician (see CMS Pub. 15-1 §2108.11, Exhibit I).

The Board acknowledges the time study prepared by the Provider that shows almost 50 percent of the physician assistants' time spent in non-patient care activities.¹⁰ The Board finds the study substantive in nature, and perhaps conservative, meaning that even more time may have been spent in non-patient care activities than the results of the study imply. However, the study alone does not satisfy the program's requirement for the submission of a properly drafted and executed allocation agreement.

Finally, the Board notes that in the absence of a written allocation agreement, 42 C.F.R. §415.60(f)(2) requires the Intermediary to assume that 100 percent of physician compensation costs is allocated to services to beneficiaries. Therefore, none of the physician assistant emergency room availability costs would be allowable under Medicare Part A.

DECISION AND ORDER:

The Intermediary was correct in its determination that no costs for physicians' assistants' emergency room availability are allowable as Medicare Part A reimbursable expenses. The Intermediary's denial of the Provider's request to include these costs in its cost report is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: December 15, 2006

Suzanne Cochran, Esq.
Chairman

¹⁰ Tr. at 54. Exhibit P2-P8, 43 of 43 (Emergency Room Down Times-July 1, 1999 through June 30, 2000).