CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Mariners Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 2012, 2013 & 2014**
Provider	
vs.	
Medicare Administrative Contractor - First Coast Service Options, Inc.	**Review of: PRRB Dec. No. 2019-D22 Dated: March 28, 2019**

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 parties were notified of the Administrator's intention to review the Board's decision. The Medicare Administrative Contractors' (MAC) submitted comments, requesting that the Board's decision be reversed. The Provider submitted comments, requesting that the Administrator affirm the Board's decision. The Center for Medicare (CM) submitted comments, requesting that the case be remanded to the MAC. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a 25-bed Critical Access Hospital located in Tavernier, Florida. During the fiscal periods under dispute, the Provider contracted with Anesthesia Associates of Greater Miami to provide anesthesia services and with Criticare to provide emergency services. The Provider claimed that these costs are reasonable hospital costs under Medicare Part A. The MAC disallowed these costs because the Provider did not submit allocation agreements that distinguished between Medicare Part A services to Provider and Medicare Part B services furnished to individual patients. The MAC contents that all of the costs incurred under the Anesthesia Associates and Criticare contracts were for Part B professional services to patients. The Provider appealed.

ISSUE AND BOARD'S DECISION

The issue in this appeal is whether the MAC 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

The Board held that the MAC improperly classified payments made by the Provider for emergency and anesthesiologist service agreements as Part B cost for fiscal years 2012, 2013, and 2014. In reaching this determination the Board concluded that these costs related solely to services provided to the Provider and reimbursable under Part A. Specifically, the Board reviewed the services agreements and found that they expressly provided for the physicians to bill all patients directly for physician services and that the physicians personally received payment from or on behalf of the patients, but not from the Provider. 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. 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…" Because all of the services paid under the service agreements were for Part A services, the Provider 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 the Provider and Part B professional services to patients.

SUMMARY OF COMMENTS

The MAC submitted comments requesting that the Administrator reverse the Board's decision. In reaching this determination the MAC took exception to the Board's use of the exception found in 42 C.F.R. § 415.60(d). The MAC contended that, while the Provider certified that the compensation was attributable solely to the physician services furnished to the Provider, the physician standby and other services provided by the physicians are benefitting the Part B patients, even though the physicians billed the patients directly.

The MAC contended that some portion of the standby and administrative services that the Provider paid pursuant to the agreement, had some overlap with the Professional services (Part B) rendered to patients. The MAC contended that if the physicians were just performing other services while on standby for emergency and anesthesia services, it would not be necessary to outline these other services in the contracts. If the physicians were doing completely unrelated work while on standby, and directly billing clients for this side work, there would be no need to include these unrelated services in the contracts for standby services.

The Provider has the burden to overcome the presumption found at 42 C.F.R. § 415.60(f)(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." The Provider has not met this burden.

The Provider submitted comments requesting that the Administrator affirm the Board's decision for all of the reasons set forth in the Board's decision as well as the Provider's consolidated final position.

The CM submitted comments requesting that the cost reports at issue be remanded to the MAC to correctly apply Medicare reimbursement policy to determine the allowable amounts either as Part A services or Part B services. CM contends that the Board's direction to classify all professional services agreements (PSA) with Criticare and with Anesthesia Associates as Part A provider costs violates Medicare policy and will result in inaccurate reimbursement to the Provider because the PSA encompassed more than Part A physician availability cost and services for the Medical Director of the Emergency Department.

Although the regulations permits payment for the reasonable cost of physician availability and on-call services with respect to CAH's emergency room, the regulations do not permit payment for on-call services for responding to code blues throughout the hospital and elsewhere on the Provider's campus. Moreover, Medicare does not recognize the cost of physician availability or on-call services in any area of a CAH other than the emergency room, under very specific circumstances. However, the costs for the services of the Medical Director of the Surgical Services Department under the Anesthesia Associates PSA may be allowable physician administrative services. Therefore, further review and analysis is needed to determine what amount of the agreement is compensation for physician availability or on-call costs for the emergency room, or as Medical Director.

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 received timely are included in the record and have been considered.

The Provider in this case is a Critical Access Hospital (CAH), meaning it is paid on a reasonable cost basis, and not pursuant to a prospective payment basis.[1] With respect to reasonable cost reimbursement § 1815 of the Social Security Act states:

> …no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.[2]

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[1] Congress created the CAH designation through the Balance Budget Act of 1997 in response to a string of rural hospital closures during the 1980s and early 1990s. *See, Pub L*. 105-33.

[2] *See also Daviess County Hosp. v. Bowen*, 811 F.2d 338, 347 (7th Cir. 1987)("The anti-cost shifting provision of the Medicare statute directs that regulations promulgated by the Secretary not shift costs but cannot be read to override the Secretary's statutory authority under 42 U.S.C. § 1395(g)(a) to deny reimbursement requests not supported by sufficient cost records. The record-keeping requirements, promulgated in order to promote accurate costs determination, are

Reasonable cost is described in §1861(v)(1)(A) of the Social Security Act as the:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of 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, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of…

In addition §1861(v)(1)(A) states that:

> 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 costs 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.

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 at 42 C.F.R. §413.9 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. Reasonable cost includes all necessary and proper costs 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. 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.

The regulation at 42 C.F.R. § 413.9 states that reasonable costs include "normal standby" cost, which indicates that only "normal" 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

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themselves intended to aid in avoiding cost-shifting; denial of reimbursement under §1395g(a) is simply Congress' chosen method for enforcement of the record-keeping and cost-reporting rules.).

the PRM indicates that standby costs are defined as those attributable to 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. Moreover, the payment methodologies for physician services are specifically addressed in the statute and in the regulation.

Physician services

The regulations governing provider-based physician services are found at 42 C.F.R. subpart 415[3] and sets forth rules in determining payments to providers for physician services, .Part B carrier payments for physician services to beneficiaries in providers, and physician services in teaching settings, and services of residents. The regulation at 42 C.F.R. §415.55 provides for general payment rules and sets forth that the costs a provider incurs for services of physicians are allowable only if the following conditions are met:

> (1) The services do not meet the conditions in §415.102(a) regarding fee schedule payment for services of physicians to a beneficiary in a provider.
> (2) The services include a surgeon's supervision of services· of a qualified anesthetist, *but do not include physician availability services, except for reasonable availability services furnished for emergency rooms* and the services of standby surgical team physicians.
> (3) The provider has incurred a cost for salary or other compensation it furnished the physician for the services.
> (4) The costs incurred by the provider for the services meet the requirements in § 413.9 of this chapter regarding costs related to patient care.
> (5) The costs do not include supervision of interns and residents unless the provider elects reasonable cost payment as specified in § 415.160, or any other costs incurred in connection with an approved GME program that are payable under§§ 413.75 through 413.83 of this chapter.

In addition, 42 C.F.R. §415.55(b) sets forth that the provider must follow the rules in 42 C.F.R. §415 .60 regarding allocation of physician compensation costs to determine the costs of services. Finally, under (c), the MAC/intermediary must apply the limits on compensation set forth in § 415.70 to determine its payments to a provider for the costs of services unless certain exceptions apply.

[3] This part is based on the provisions of the following sections of the Act: Section 1848 establishes a fee schedule for payment for physician services. Section 1861 (q) specifies what is included in the term "physician services" covered under Medicare. Section 1862(a)(l4) sets forth the exclusion ofnonphysician services furnished to hospital patients under Part B of Medicare.

In 1983, pursuant to a response to comments when revising 42 C.F.R. §405.480 (now 42 CFR 415.55) the Secretary explained the treatment of physician standby and availability services, as reflected in now 42 C.F.R. §415.55 (a)(2):

> Standby and availability services. Comment: Some physicians, particularly anesthesiologists; have expressed concern about the proposed elimination of physician availability and standby services from allowable provider costs (proposed §405.480(a)(2)). They believe we should distinguish between physician "availability" and "standby" services.
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> Response: We agree. The cited section of the proposed regulation was intended to apply to situation in which a hospital incurs costs in connection with a physician's being generally available to furnish services if a need should arise. The expense attributable to such availability is currently reimbursable as an allowable cost only when it is incurred by a provider in connection with an emergency room agreement that meets very specific criteria. Our proposed rule continues this policy. Also, we do not intend to restrict payment for "standby" services when a physician is physically present in an operating suite monitoring the patient's condition, making medical judgments regarding the patient's anesthesia needs, and ready to furnish anesthesia services, as necessary, to a specific ,patient who is known to be in potential need of such services. For example, when an aged individual is given a local anesthetic for performance of a surgical procedure because of the general state of his or her health, it is also recognized that it may become necessary to administer general anesthesia during the operation, and an anesthesiologist may be physically present in the operating suite and standing by to furnish the services as needed. Such services may be payable on a reasonable charge basis.
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> Although in the NPRM we referred to both standby and availability services, the final regulations refer only to availability services. This is not a change of policy but a clarification of terms. Despite sometimes inconsistent past usage, we wish to make clear that "standby services~' are related to services for a particular patient, and the physician's services resulting from such standby are reimbursable on a reasonable charge basis. "Availability services" are general services related to expectations of need by unspecified patients, such as provided by emergency rooms. Such availability services are reimbursable on a reasonable cost basis, *but only when the. costs of the services are incurred in connection with an emergency room agreement that meets certain specific criteria.*[4] (Emphasis added.)

[4] 48 Fed.Reg. 8902, 8908 (March 2, 1983)(Medicare Program; Payment for Physician Services Furnished in· Hospitals, Skilled Nursing Facilities, and Comprehensive Outpatient Rehabilitation Facilities.)

The Secretary subsequently revised this language again in 1993 to add the phrase "and the services of standby surgical team physicians" in order to prevent billing of these particular services to beneficiaries.[5]

The regulation at 42 C.F.R. §415.60 addresses the allocation of physician compensation costs and states that, 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);[6] and (3) Activities of the physician, such as funded research, that are not paid under either Part A or Part B of Medicare.

In addition, pursuant to paragraph (c), only costs allocated to payable physician services to the provider (as described in § 415.55) are allowable costs to the provider under this subpart. Generally, the total physician compensation received by a physician is allocated among all services furnished by the physician, unless, as specified in paragraph (d)(l) 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 pa1rnent from or on behalf of the patients.

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[5] While the payment for a "standby surgical team" is not at issue here, CMS provided at 58 Fed. Reg.37994, 38005 (July 14, 1993) (Medicare Program; "Revisions to Payment Policies Under the Physician Fee Schedule (proposed rule)), the rational for this provision: "The services of the standby surgical team are not considered covered physician services because no physician service is actually furnished. Recently, some physicians have been billing beneficiaries for their standby or "availability." This billing has been most prevalent by thoracic surgeons who have charged for their availability in the event that a patient undergoing an angioplasty procedure by a cardiologist does not require an emergency bypass procedure. Since the charges are not for a covered physician's service, there is no Medicare limiting charge. While it may be good medical practice to have a surgical team available in these situations, we continue to believe that this availability is not a covered physician service to an individual patient. Rather, we view the surgeon's availability as a service benefitting all patients receiving that particular service. If any payment is made to a physician for his or her availability, it should be made by the hospital and not by the patient or the Medicare program. Currently, §405.480(a) limits payment to hospitals for physician availability services furnished for emergency rooms. We propose to revise §405.480(a)(2) to include the activities of the standby surgical team as covered physician availability services. Since these services would be paid directly by the hospital, the physician would no longer be able to bill the beneficiary for these services." 58 Fed. Reg. 63626, 3641-63642 (Dec. 2, 1993)(final rule).(Medicare Program; Revisions to Payment Policies and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1994)

[6] 42 C.F.R. §415.102 Conditions for fee schedule payment for physician services to beneficiaries in providers. (a)General rule. If the physician furnishes services to beneficiaries in providers, the carrier pays on a fee schedule basis provided the following requirements are met: (1) The services are personally furnished for an individual beneficiary by a physician. (2) The services contribute directly to the diagnosis or treatment of an individual beneficiary. (3) The services ordinarily require performance by a physician. (4) In the case of radiology or laboratory services, the additional requirements in§ 415.120 or§ 415.130, respectively, are met. (b)Exception. If a physician furnishes services in a provider that do not meet the requirements in paragraph (a) of this section, but are related to beneficiary care furnished by the provider, the intermediary pays for those services, if, otherwise covered. The intermediary follows the rules in §§ 415.55 and 415.60 for payment on the basis of reasonable cost or PPS, as appropriate.

Under 42 C.F.R. §415.60(f) , the intermediary pays the provider for these costs only if, inter alia, 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 the compensation is reasonable in terms of the time devoted to these services. 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.

Consistent with §1815 of the Act, the regulation at 42 C.F.R. §4 15.60(g) also addresses recordkeeping requirements so that except for services furnished in accordance with the assumed allocation under paragraph (e) of this section, each provider that claims payment for services of physicians under this subpart must meet all of the following requirements: (1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier. (2) Report the information on which the physician compensation allocation is based to the intem1ediary or the carrier on an annual basis and promptly notify the intermediary or carrier of any revisions to the compensation allocation. (3) Retain each physician compensation allocation, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.

CAH Payments

The specific rules applicable to CAHs and CAH payments are set forth at Social Security Act at §§ 1814(a)(8), 1814(1), 1820, 1834(g), 1834(1)(8), 1883(a)(3), and 186l(v)(l)(A) and the CFR at 42 CFR §§4 l0.152(k), 412.3, 413.70, 4I3. ll4(a), and 424.15. The regulation at 42 C.F.R. §413.70 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 CAH. Pursuant to 42 C,F.R.§413.70 , Payment for services of a CAH, explains that payment for inpatient services furnished by a CAH[7] is determined in accordance with § 1861(v)(l)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services: Reasonable compensation equivalent (RCE) limits for physician services to providers; and payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients. Paragraph (b)(4) provides that:

(4) Costs of certain emergency room on-call providers.

[7] (b) Payment for outpatient services furnished by CAH - (1) General. (i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is determined under paragraph (b)(2) of this section. (ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.

> (i) 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 physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.

The related preambles also emphasize that physician on-call costs are generally not allowable in a hospital and are only allowable for a CAH in the emergency room setting. In the preamble to the August 1, 2001 final rule, CMS discussed the implementation of 42 C.F.R. § 413.70(b)(4) and stated that, under existing policy at that time, the reasonable cost of CAH services to outpatients may not include any costs of compensating physicians who are not present in the facility but on call.[8] CMS added a new paragraph (4) to 42 C.F.R. § 413.70(b) to permit the reasonable costs of CAH outpatient services to include the reasonable compensation and related costs of emergency room on-call physicians under the terms and conditions specified in the statute. In doing so, the August l, 2001 preamble stated that 42 C.F.R. § 413.70(b)(4) is to only reimburse reasonable physician on-call costs that are related to the emergency room and not in other outpatient settings. Thus, in. contrast to normal facility standby costs which would include the cost of depreciable assets, the, costs for the "availability" of physician services are only allowable as

[8] 66 Fed.Reg. 39828, 39922 (Aug. 1, 200l) (Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems arid Rates and Costs of Graduate Medical Education: Fiscal Year 2002 Rates; Provisions of the Balanced Budget Refinement Act of 1999; and Provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000) ("4. Payment to CAHs for Emergency Room On-Call Physicians (§ 413.70(b)(4)) Under section 1834(g) of the Act, Medicare payment to a CAH for facility services to Medicare outpatients is the reasonable costs of the CAH in providing such services. The term "reasonable cost" is defined in section 1861(v) of the Act and in regulations at 42 CFR Part 413, including, with specific reference to CAHs, § 413.70. Consistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15-1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary). However, under existing policy, the reasonable cost of CAH services to outpatients may not include any costs of compensating physicians who are not present in the facility but are on call.") As noted in the May 12, 1998 final rule, prior to this change for CAHs, no payment for on-call physician costs was available to hospitals 9incldUing CAHS), regardless of where the on-call services were rendered. See 63 Fed. Reg. 26318,26353 '(May 12, 1998) ("As is the case for full-service hospitals, standby costs of emergency room physicians who are present at the emergency room are allowable costs and will, to the extent they are reasonable in amount, be taken into account in computing Medicare payment. However, Medicare does not recognize costs of "on-call" physicians as allowable costs of operating a CAH.")

defined in PRM § 2109[9] and 42 C.F.R. § 413.70(b)(4) and the costs of on-call physician services are only allowed for CAHs under the specific terms of 42 C.F.R. § 413.70(b)(4).

Case Findings

In this case, as a CAH, the Administrator finds that the Provider is reimbursed for services provided to Medicare beneficiaries on a reasonable cost basis. Medicare policy allows a provider to claim, as allowable costs, only those costs incurred for physician services that benefit the general patient population of the provider or that represent availability services in a hospital emergency room under specified conditions. CMS has stated that physician "standby services" are related to services for a particular patient, and the physician's services resulting from such standby are reimbursable on a reasonable charge basis. "Availability services" are general services related to expectations of need by unspecified patients, such as provided by emergency rooms. Such availability services are reimbursable on a reasonable cost basis, but only when the costs of the services are incurred in connection with an emergency room agreement that meets certain specific criteria. In this case it would be those services meeting the criteria of 42 C.F.R. 415.70(a)(4).[10]

Consequently, while the contracts indicate that the contractors will bill for physician services, the following language in the Agreements, for example, are problematic with respect to the contracting services and classification of those services as Part A costs. The Criticare agreement stated that the respective professionals will be: "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 MH campus, including but not limited to the Tassell Medical Arts Building in accordance with the Hospital's policies and procedures." Similarly, the Anesthetics Associates' agreement provided that the contractor: "cause Physicians to be available to provide Anesthesia Services, ... to Patients in an exclusive basis, twenty-four (24) hours per day, seven (7) days per week with an adequate number of Physicians on duty on the premises of the Hospital or on call at all limes (which in no event shall be fewer than one (1) Physician as reasonably determined by MH in consultation with the Medical Director."[11] In addition each agreement respectively provided for the contracting of a Medical Director, respectively for the Emergency Department and for the Surgical Department.

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[9] The Provider Reimbursement Manual (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.

[10] *See also* Administrator Decisions in *Community Hospital of Anaconda,* PRRB Dec. No. 2014-D29, *Marias Medical Center,* PRRB Dec. No. 2008-Dl0.

[11] Also problematic is the reference to CRNA staff in the contract. See section 4.1. 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. 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 and does not specify CRNAs. Anesthesia services furnished by hospital or CAH employed nonphysician anesthetists or obtained under arrangements are addressed at 42 C.F.R. 412.113.

The regulation at 42 C.F.R. §415.55 specifically provides that the costs a provider incurs for services of physicians are allowable only if the following conditions are met. These conditions include a surgeon's supervision of services of a qualified anesthetist, but do not include physician availability services, except for reasonable availability services furnished for emergency room. "Standby services" are related to services for a particular patient, and *the physician's services resulting from such standby* are reimbursable on a reasonable charge basis. "Availability services" are general services related to expectations of need by unspecified patients, such as provided by emergency rooms. Such availability services are reimbursable on a reasonable cost basis, but only when the costs of the services are incurred in connection with an emergency room agreement that meets certain specific criteria. In addition, the compensation of the medical directors may be payable under Part A. However, the record shows that the Provider's agreement required one lump sum for a wide variety of services to the Provider, including medical director services and physician availability and on-call services. The agreements did not separately identify the costs for the categories of services which on their face are not all payable under Part A and if payable under Part A, only under certain limited circumstances that must be met.

While the Provider argued it could certify that all contractor costs are related to Part A services, because the physicians agreed to bill for beneficiary service, this approach overlooks the fact that certain services identified in the contracts are not allowable Part A costs or are incidental to Part B services. The mixing of the payment of a variety of such services necessitates the allocation of costs 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. The regulations at 42 C.F.R. § 415.60(f)(2) states that "[i]n the absence of a written allocation agreement, the intermediary assumes, for purposes of determining reasonable cost 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 case, a necessary allocation of the agreement costs was not provided and, thus, the Administrator finds that the MAC was correct based on the information it had to allocate the service cost to the professional component on Worksheet A-8-2.

However, the Administrator may direct the Board on remand' to take further action for the development of additional facts or new issues, or to consider the applicability of laws or regulations *other than those considered* by the Board. The Board incorrectly found the type of availability and standby services at issue are not physicians' service to patients, but rather are Part A provider services because none of the contracted services at issue were beneficiary specific. Per 42 C.F.R. § 415 .102(b), the Board incorrectly determined that 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", when the, regulation specifies that physician availability services are not generally provider Part A reasonable cost services at 415.55(a)(2) and, specifically, not CAH Part A services at 413.70(b)(4), except under very narrow circumstances.

In light of the Board's incorrect legal finding in evaluating this Provider's claim for costs, remand would be appropriate for further development of the facts as to whether the Provider can

document the portion of the agreements costs related to Part A services (i.e., Medical Director Administrative costs, etc.), costs related to Part B, and that part of the contracted services not payable under Part A or Part B.

Accordingly, the Board's decision is vacated and the case remanded for further findings on the portion of the costs of the contracts that are related to Part· A consistent with this order.

A Board decision on the allowable Part A costs associated with these contracts will be subject to 42 CFR 405.1875.

Date: May 28, 2019

/s/
Demetrios L. Kouzoukas
Principal Deputy Administrator
Centers for Medicare & Medicaid Services