CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Trenton Psychiatric Hospital **Provider** **vs.** **Blue Cross and Blue Shield Assn./ Riverbend Government Benefits Administrator** **Intermediary**	**Medicare Reimbursement for Cost Years Ending: 06/30/96, 06/30/97, 06/30/98, 06/30/99** **Review of: PRRB Dec. No. 2006-D3 Dated: November 17, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. The parties were notified of the Administrator's intention to review the Board's decision. Comments were subsequently received from the Provider. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue was whether the Intermediary's adjustments to disallow reimbursement for physicians' professional services on a reasonable cost basis was proper.

The Board found that the Intermediary's adjustments were improper. The Board stated that, while it was unclear how the Provider billed for physician services prior to the 1996 cost year, it was undisputed that the Provider met the regulatory conditions for an election to bill for physician services on a reasonable cost basis during the cost years at issue. Reviewing the governing regulations, the Board concluded that the Provider was not required to make an election annually or that the Intermediary had to approve an election. The Board found that the Provider's December 19, 1991 and May 12, 1993 letters to the

Intermediary, in conjunction with the as-filed cost report claiming cost-based reimbursement for physician services, qualified as an election for each cost year at issue.

The Board further found that the June 3, 1993 and November 15, 2001 Intermediary letters ignored the reasonable cost option in the regulations, even though the Provider specifically referenced the regulations in its letters. The Board noted that the Intermediary's June 3, 2001 denial letter mentioned only that the Provider should be reimbursed by the Part B Carrier for Part B services, and that teaching physicians are reimbursed through the Graduate Medical Education (GME) full-time equivalent (FTE) per-resident amount for their Part A teaching time. The letter neglected the alternative reimbursement methodology provided in the regulations.

The Board also discounted the Intermediary's November 15, 2001 letter, based on the Provider's "'waiving'" of the election due to the Provider billing Part B for physician services. The Board found that the Provider reasonably "billed" Part B, following the Intermediary's instructions, in case the Provider's cost report claim for reimbursement was denied. Section 2148.5 of the Provider Reimbursement Manual stated that, in such a situation, reimbursement should be reduced by prior payments to the Provider for the same services. Finally, the Board state that 42 CFR 405.521(d)(3) of the regulations instructs the Intermediary on how to compute the GME per-resident amount in situations such as the instant case. In conclusion, the Board reversed the Intermediary's adjustments and remanded the case to the Intermediary for the calculation of reimbursement on a reasonable cost basis.

SUMMARY OF COMMENTS

The Provider's position was that review of the Board's decision was unnecessary as none of the considerations for Administrator's review at §495.1875(c) are present in this case. The Provider argued that the Board's decision should be affirmed because it is consistent with the uncontested facts and the governing law, as documented by the Provider in its submissions to the Board. Moreover, the Provider contended that it refuted the Intermediary's legal arguments point by point. The Board properly considered both parties' arguments and concluded that there was no merit to the Intermediary's position. The Provider further suggested that the Intermediary's attempts to deny it reasonable cost reimbursement to which it was entitled were at best misinformed and at worst, bad faith, and should not be countenanced. In addition, the Provider maintained that any CMS ruling to resolve policy issues invoked by this case cannot be applied retroactively to the cost years at issue; thus, the regulations and the Board's reasonable interpretation thereof should control in this case. Finally, the Provider pointed out that it had properly established jurisdiction in this case, in conformance with the regulations.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments received after entry of the Board's decision have been incorporated into the record and considered.

Pursuant to section 1861(b)(7) of the Act, a teaching hospital may elect to be paid on a reasonable cost basis for physician services provided by its faculty physicians if all physicians in the teaching hospital agree not to bill for their services rendered to Medicare beneficiaries in the hospital. The implementing regulations for teaching physician services applicable to the cost years in this case are set forth at 42 CFR 405.521(d) (redesignated at 42 CFR 415.160). The regulation also provides, as an alternative criteria for electing reasonable cost payment, that the physicians are employees of the hospital and, as a condition of employment, are precluded from billing for these services.[1] In addition, the regulation at 42 CFR 405.521(d)(5) (1994) provides that:

> For cost reporting periods beginning after July 1, 1985, a teaching hospital that elects payment for the direct medical and surgical services of its physicians in accordance with paragraph (d)(2) of this section must, for purposes of calculating the per residents amounts described in 413.86(e) of this chapter, remove from its graduate medical education base period costs, as defined in 413.86(d) of this chapter, these costs relating to the supervision of interns and residents in approved programs related to the care of individual patients. [2] (Emphasis added.)

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[1] Section 2148.5 of the Provider Reimbursement Manual addresses the election to receive reasonable cost reimbursement. This PRM provision was originally promulgated in 1975 and refers to cost years beginning after June 30, 1975 and before July 1, 1976. (Transmittal No. 132) The original statutory provision established pursuant to Section 227 of the Social Security Amendments of 1972 (P.L. 92-603) and Section 15 of the Social Security Amendments of 1973 (P.L. 92-233), was continued on a temporary basis by section 7 of the End Stage Renal Disease Program Amendments of 1978 (P. L. 95-292.) and, subsequently, reaffirmed by section 948 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499).

[2] The election rules were redesignated in 1995 to 42 CFR 415.160 (1996) effective July 1, 1996 and this paragraph appears to have been omitted. See 60 Fed Reg. 6314 (December 8, 1995)(final rule); 60 Fed Reg. 38400 (July 26, 1995) (proposed rule)("The election and payment mechanisms described in current §§ 405.465 and 405.466 would be set forth in this proposed rule in new § 415.160 and in redesignated §§ 415.162 and 415.164" Id. At 38407); ('*Redesignation of Regulations on Teaching Hospitals, Teaching Physicians, and Physicians Who Practice in Providers.* As a part of this rulemaking process, we would redesignate the

The Administrator agrees that, at least by the Provider's second letter dated May 1993, the Provider had requested the reasonable cost election. In addition, the PRM appears to allow a provider to offset the Part B payments against reasonable costs payment made under the election to prevent duplicate reimbursement for the same services.

The Board recognized that an adjustment would also need to be made to the Provider's GME average per resident amount for those cost years and, implicity, that the Provider's GME payment maybe reduced. However, the regulation specifies that it is a provider's responsibility to ensure that there is no duplicate reimbursement of these costs in the provider's GME APRA. A provider cannot receive the benefits of the reasonable cost election unless these costs are removed from the APRA based upon appropriate documentation. The issue of whether the Provider has sufficient documentation to remove these costs from its APRA as a condition of the Provider being reimbursed under the reasonable cost election was not addressed before the Board. The Administrator finds that it is appropriate to remand this case to the Board to address whether the Provider can present sufficient documentation to remove these costs from its APRA in accordance with 42 CRR 405.451 (d)(5) and ensure that there will be no duplicate payments.[3]

Accordingly, the Administrator vacates the Board's decision and remands this case for further development of the issue on whether the Provider has the documentation to remove these costs from its APRA and ensure that there is no duplicative payment of these costs as a condition for granting the reasonable cost election.

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regulations currently set forh in §§ 405.465 and 405.466, 405.480 through 405.482, 405.522 through 405.524, 405.550, 405.551, 405.554, 405.556, and 405.580 into a new part 415, along with the new regulations proposed in this rule…Except as indicated below, we are making only technical changes to conform cross-references, and no substantive changes are included. We would remove §§ 405.520 and 405.521 because the applicable rules for payment of services are obsolete…" Id. at 38412").

[3] The record indicates that the Provider has not taken into account the possible impact on its GME payment in electing the reasonable cost payment for these services.

After allowing the parties sufficient opportunity to develop the record on this issue, the Board shall determine whether Provider has the documentation necessary to comply with 42 CFR 405.521(d)(5).

The Board's decision shall be in subject to Section 1878 of the act and 42 CFR 405.1875.

Date: 1/18/06 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services