CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Community Hospital of Anaconda	**Reimbursement Determination for Period Ending:**
	December 31, 2005
Provider	
vs.	
Noridian Administrative Services/ Blue Cross and Blue Shield Association	**Review of: PRRB Dec. No. 2014-D29**
Intermediary	**Dated: September 24, 2014**

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)). Comments were received from CMS' Center for Medicare (CM) requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Medicare Administrative Contractor's (MAC's) disallowance of the Provider's certified registered nurse anesthetist ("CRNA") on-call costs was proper.

The Board found that the Provider's business decision to use a contracted CRNA and incur the standby costs at issue was an attempt to limit its costs and pay only what a "prudent and cost conscious buyer" would pay for CRNA services. The Board stated that the standby costs met the reasonable cost standards of 42 C.F.R.

§ 413.9 and PRM 15-1 §2102.1 and the costs are allowable under the Medicare program.
Finally, the Board found that there was no evidence that it was "longstanding" CMS policy to never allow unspecified standby costs, and found support in the statute, regulations and program instructions that the opposite is true provided that the standby costs were reasonable and necessary.

SUMMARY OF COMMENTS

The CM submitted comments stating that the Board's decision should be reversed since the Board erroneously ruled that the MAC's disallowance of independent contractor costs for the provision of on-site and on-call CRNA services was improper. CM further stated that on-call costs for CRNAs at critical access hospitals (CAHs) are not authorized by any provisions in the Social Security Act, Medicare regulations or Medicare program guidance or issuances.

DISCUSSION

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

The Provider is a rural hospital that is located in Anaconda, Montana and participates in the Medicare program as a CAH. The Provider contracted with an independent third party to oversee its Anesthesia department and provide CRNA services. The third party provided on-site services for the benefit of the Provider and its medical staff as well as on-call related services. For its fiscal year ending December 31, 2005 (FY 2005), the Provider claimed $65,689 for the payments that it made to its third party contractor for on-call related services. The MAC conducted an examination of the Provider's claimed costs and disallowed the amounts claimed for CRNA on-call costs in their entirety for FY 2005.

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

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.[1] 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.[2] 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.

In addition to the reasonable cost principles outlined in 42 C.F.R. §413.9 of the regulation, the regulation at 42 C.F.R. §413.704[3] provides that providers designated as Critical Access Hospitals will be paid reasonable cost for inpatient services furnished to Medicare beneficiaries. These sections of regulation apply in determining reasonable cost for the Provider, however, none of the sections of the regulation identifies CRNA "standby" costs as a reasonable cost.

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

> Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in

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[1] See e.g. 42 C.F.R. §413.9.

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

[3] 42 CFR 413.70(a) and (b) respectively state that "payment for" [inpatient and outpatient services] "of a CAH is the reasonable costs of the CAH in providing CAH services … as determined in accordance with Section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in Part 415 of this chapter." The regulation then sets forth specific exceptions not at issue in this case.

> order that, under the methods of determining costs, the necessary cost of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and …

The regulation at 42 C.F.R. §413.9 states that reasonable costs include "normal standby" costs, which indicates that only some standby costs would be allowable. While the term "normal standby" cost is not defined in the regulations, the Provider Reimbursement Manual (PRM) includes several examples of situations in which standby costs are allowable. Section 2102.1 of the PRM indicates that standby costs are defined as those attributable to unoccupied beds (depreciation, operation of plant, etc.). In addition, the PRM at §2342 states:

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

The "standby" costs specifically included by statute are related to the provider's physical plant or structure and not related to the personnel staffing the hospital. In contrast, costs for "availability" of personnel and costs for personnel to be on-call are only allowable as defined in PRM §2109 and 42 C.F.R. §413.70(b)(4). The CRNA costs included in the Provider's cost report as "standby cost" are not a cost of services provided and are not allowable as either "availability" costs or as "on call" costs. PRM §2109.2 defines "availability" as the physical presence of a physician in a hospital. PRM §2109.1 states:

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

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

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

> Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician

> who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physician's services, and is not on call at any other provider or facility.

Effective January 1, 2005, the reasonable costs of a CAH's outpatient services also can include amounts for reasonable compensation of emergency room physician assistants, nurse practitioners, and clinical nurse specialists who are on call off-site, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility.[4] The on call costs for a CAH are recognized only for the CAH's emergency room, and only as described in that section of the regulation. The cost for any other on call personnel not specified in the regulations is not an allowable cost.

In addition, while 42 C.F.R 412.113(c) provides for reasonable cost reimbursement for non-physician anesthetists, this regulation must be read in context of the general reasonable cost regulations. As the definition of "reasonable costs" does not include the types of costs claimed by the Provider, these standby costs, similarly, cannot be found to be reasonable CRNA costs.[5]

In light of the foregoing, the Administrator finds that the Board's decision was improper. The "standby" costs claimed by the Provider in this case are not attributable to unoccupied beds (depreciation, operation of plant), the physical presence of a physician in the CAH's emergency room, nor the costs for approved non-physician specialists in a CAH's emergency room after January 1, 2005. Instead, in this case, the Provider contracted with a third party to "outsource" the oversight of its Anesthesia department and provide CRNA services. The third party's provision of on-site services for the benefit of the Provider and its medical staff as well as on-call related services are not costs which are recognized under the existing statutes or regulations as reasonable costs for reimbursement under the Medicare program. Accordingly, the Administrator reverses the Board's decision in this case.

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[4] See, 42 C.F.R. 413.70(b)(4).

[5] In the case at bar, the Board cites *St. Luke Community Healthcare*, (PRRB Dec. No. 2009-D9), where the Board similarly found that a CAH was entitled to CRNA on-call costs and was reversed by the Administrator. The Administrator notes that the U.S. District Court of the District of Montana upheld the Administrator's decision in *St. Luke*. (See: *St. Luke Comm. Healthcare*, 2010 WL 1839411, D. Mont. 2010 (not reported in F.Supp.2d)). The District Court reasoned that, because CRNA on-call costs are not permissible costs to CAHs via the Medicare statutes and regulations, the Board cannot infer same when the Secretary is entitled to deference on the matter.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 11/18/14

/s/
Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services