PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D40

PROVIDER -
Marias Medical Center
Shelby, Montana

Provider No.: 27-1328

vs.

INTERMEDIARY
BlueCross BlueShield Association/
Blue Cross and Blue Shield of Montana

DATE OF HEARING -
December 13, 2007

Cost Reporting Period Ended -
June 30, 2004

CASE NO.: 06-0987

INDEX

ISSUE:

Whether the Intermediary's adjustment to Certified Registered Nurse Anesthetist (CRNA) cost was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. 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 the providers under Medicare law and under interpretive 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. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

42 U.S.C. §1395x(v)(1)(A) mandates that for a payment to be considered a reimbursable cost under Medicare, the payment must be the cost actually incurred, and should exclude any cost found to be unnecessary. 42 C.F.R. §413.9 states that payments to providers must be based on the reasonable cost of services covered under Medicare and defines reasonable cost to include all necessary and proper costs. 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Marias Medical Center (Provider) is a 20 bed, Critical Access Hospital (CAH) located in Shelby, Montana. The Provider was certified as a CAH on October 1, 2002. Prior to that time, the Provider had been designated a sole community provider by Medicare. Since at least 1991, the Provider had elected to be cost reimbursed for CRNA services.[1]

[1] See, TR. 22-23 and Exhibit P-13.

In 2000, the Provider contracted with a CRNA to provide non-physician anesthesiology services under arrangement as an independent contractor.[2] The contract contained a provision for the payment of standby costs to the CRNA. The Provider included $40,717[3] of cost relating to the CRNA standby costs on its June 30, 2004 cost report. Blue Cross Blue Shield of Montana (Intermediary) audited that cost report and denied reimbursement for the standby costs. This resulted in a reduction of Medicare reimbursement of approximately $16,328.[4]

The Provider appealed the Intermediary's adjustment to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Lucian Bernard, Esquire, of Pearson & Bernard, PSC. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary asserts that both 42 C.F.R. §413.9 and 42 C.F.R. §413.70 apply in determining reasonable cost for this provider, and neither identifies CRNA standby costs as a reasonable cost. The Intermediary argues that 42 C.F.R. §413.9 states that reasonable costs include "normal standby" costs, therefore indicating that some standby costs would be allowable and some would not. While the term "normal standby" cost is not defined in the regulations, the Provider Reimbursement Manual (CMS Pub.15-1) includes several examples of situations in which standby costs are allowable. The Intermediary argues that it is long standing policy of CMS to recognize standby costs as allowable under 42 C.F.R. §413.9 only if specifically identified by the Secretary in regulations or program instructions.

Since the Providers is a CAH, the Intermediary contends that 42 C.F.R. §413.70, *Payment for services of a CAH*, is the regulation which governs this case. The Intermediary argues because the regulation specifically addresses standby cost for physicians, physician assistants, nurse practioners and clinical nurse specialists, but not CRNAs, standby costs for CRNAs would not be considered a reasonable or necessary cost for a CAH.

The Provider points to the statute at 42 U.S.C. §1395x(v)(1)(a), the regulation at 42 C.F.R. §413.9(c)(3) and CMS Pub. 15-1, at §2102.1 to show that Medicare allows for reasonable standby costs. The Provider contends that the Intermediary's use of 42 C.F.R. §413.70(b)(4) as an exclusive list of the only standy costs that CAH would be paid contradicts these general sections.

The Provider further contends that the Intermediary's interpretation of 42 C.F.R. §413.70(b)(4) as omitting CRNAs from the list of recognized standby costs is insupportable in that the regulation section labeled *Costs of certain emergency room on-call providers* strictly applies to Emergency Room procedures. During the June 30, 2004

[2] See, Exhibit P-10.
[3] See, Stipulated Fact No. 5.
[4] See, Provider Post hearing Brief page 3.

cost reporting period, the Provider's CRNA participated in approximately 400 procedures, both on inpatients and outpatients, however less than 1% of the procedures were performed in the emergency room. Therefore, although §413.70 governs payments for a CAH, 42 C.F.R. §413.70(b)(4) by its own terms, would not apply to standby CRNA services in a CAH outside of the emergency room, and would not be controlling in this situation.

FNDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board finds and concludes as follows:

There is no statute, regulation or guideline which specifically addresses whether CRNA standby costs incurred by CAH are allowable. The Board finds that several rules, when read together, authorize payment for CRNA standby cost. Those provisions are as follows:

- 42 U.S.C. §1395x(v)(1)(A) recognizes that standby costs may be reasonable or necessary costs. The Act instructs that the Medicare reasonable cost regulations shall "take into account both direct and indirect costs of the provider 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 . . ." (emphasis added)

- The reasonable cost regulation at 42 C.F.R. §413.9(c)(3), also provides that "normal standby" cost could be counted in the determination of reasonable cost. The regulation reads: "The determination of reasonable costs of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs." (emphasis added)

- CMS Pub. 15-1 §2102.1 also includes the term standby costs in its discussion of reasonable costs: "Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs." (emphasis added)

The Board finds nothing in the above references that specifically precludes standby costs from being included in reasonable cost. The Board concludes that the statute, regulations and program instructions contemplate that normal standby costs are considered reasonable costs. Therefore, the Intermediary's conclusion that the controlling reasonable cost principles only allow standby costs that are specifically identified as allowable is without merit.

The Intermediary relied on 42 C.F.R. §413.70, "Payment for services of a CAH," to support its position that CRNA standby costs are not specifically identified as

"allowable," therefore, they must be "non-allowable." The section of the regulation the Intermediary argues is pertinent to this case, 42 C.F.R. §413.70(b)(4), entitled *Costs of certain emergency room on-call providers*, is specific to on-call providers in an emergency room setting.[5] The Board finds that the evidence in this case is consistent with what the Board understands to be typical of CRNA services, which is that generally, CRNAs would not work in an ER setting. Specifically in this case, less than 1% of CRNA services were performed in the emergency room.[6] Therefore, CRNAs would not be considered emergency room personnel under 42 C.F.R. §413.70(b)(4) and this regulation would not apply to CRNA standby services.

As the Board has found that 42 C.F.R. §413.70(b)(4) does not apply and therefore does not preclude the Provider from claiming CRNA standby costs, the Board looks to 42 C.F.R. §412.113(c) which specifically allows CAHs to use CRNAs and to be paid on a reasonable cost basis. The Provider has maintained that it met all the requirements for the reimbursement of reasonable costs for CRNA services, which in this specific case included services provided under arrangement and included standby costs. The Provider has demonstrated that contracting with a CRNA to provide services under arrangement, including paying standby costs, actually saved the Provider over $70,000 per year versus hiring a CRNA on staff. The Provider testified that due to the Intermediary's decision in the June 30, 2004 cost report to disallow the standby costs, the Provider was forced in the following year to hire a full-time CRNA, costing the program more money than it had in previous years using the contracted services. The Board finds that both 42 C.F.R. §413.9 and CMS Pub.15-1 §2102.1, attempt to limit expenditures. CMS Pub. 15-1 §2102.1 reads:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do no exceed what a prudent and cost conscious buyer pays for a given item or service. (See §2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

The Board finds 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. Therefore, these standby costs met the reasonable cost standards of 42 C.F.R. §413.9 and PRM §2102.1 and the costs are allowable. The Board also finds that the Intermediary's interpretation of program policy forced the Provider to pay more for services in later years, in turn passing these higher costs on to the program.

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[5] The Board notes the portion of the regulation that contains the list of emergency room providers (e.g., emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist) cited by the Intermediary was not effective until January 1, 2005, the year after the year appealed.

[6] Provider's Post Hearing Brief, page 8.

Finally, the Board finds no evidence that it was "longstanding" CMS policy to never allow unspecified standby costs, and finds support in the statute, regulations and program instructions that the opposite is true provided the standby costs were uncontroverted, reasonable and necessary. This finding is further supported by the Provider's testimony that the hospital is cost reimbursed for other types of employee and contractor standby costs, such as laboratory staff and radiology technicians. The Board finds that since the CRNAs who meet the requirements of 42 C.F.R. §412.113(c) are paid on a reasonable cost basis, their standby costs would be reimbursed similarly to these other hospital staff.

DECISION AND ORDER:

The Intermediary improperly adjusted CRNA standby costs. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 29, 2008