PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D53

PROVIDER -
Henry Ford Health System
Detroit, Michigan

Provider No.: 23-0053

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC

DATE OF HEARING -
September 17, 2009

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 05-1261

INDEX

ISSUES:

1. Whether the Intermediary properly determined the Provider's full time equivalents (FTEs) counts used for purposes of calculating payment for direct graduate medical education (DGME) and indirect medical education (IME), based on its exclusion of residents in other approved programs, including unaccredited programs.

2. Whether the Intermediary properly determined the Provider's FTE counts used for purposes of calculating payment for IME based on its exclusion of residents' time for research.[1]

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 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 and 413.24.

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 receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835 (2008).

Medicare reimburses teaching hospitals for their share of costs associated with graduate medical education. It has two components: direct, referred to as DGME, and indirect, referred to as IME. The calculation for reimbursement requires a determination of the total number of full-time equivalent residents and interns in the teaching program. This case arises from a dispute over the FTE count.

Unaccredited training programs

In determining the total number of FTE residents, 42 C.F.R § 413.86(f)(1) instructs that subject to weighting factors, the count of FTE residents includes "[r]esidents in an approved program working in all areas of the hospital complex … " Historically, the statutory definition of an "approved program" for purposes of the cost reimbursement system for inpatient hospital services expressly included only those programs that were accredited by one of several

[1] This issue will be decided on the record. *See*, Transcript (Tr.) at 6, 10 and 21.

enumerated national organizations, including the predecessor to the Accreditation Council for Graduate Medical Education (ACGME). As defined by the statute, an "approved medical residency training program" means "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary." 42 U.S.C. § 1395ww(h)(5)(A). The DGME and IME regulations define the phrase "approved medical residency program" similarly. The DGME regulation defines an approved program as follows:

> *Approved medical residency program* means a program that meets one of the following criteria:
>
> (1) Is approved by one of the national organizations listed in §415.152 of this chapter.
>
> (2) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> > (i) The Director of Graduate Medical Education Programs published by the American Medical Association . . . ; or
> >
> > (ii) The Annual Report and Reference Handbook published by the American Board of Medical Specialties . . .
>
> (3) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

42 C.F.R. § 413.86(b).[2]

Likewise, the IME regulation defines an approved teaching program as one that meets one of the following requirements:

> (A) Is approved by one of the national organizations listed in
>
> §415.152 of this chapter.
>
> (B) May count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:
>
> > (1) the Directory of Graduate Medical Education Programs published by the American Medical Association:

[2] The regulation 42 C.F.R. § 413.86(b) was re-designated 42 C.F.R. § 413.75(b) on August 11, 2004. *See*, 69 Fed. Reg. 49,254 (Aug. 11, 2004). Unless indicated otherwise, the decision refers to the regulation at 42 C.F.R. § 413.86, that was in effect during the fiscal year ending December 31, 2000, the fiscal year under appeal.

> (2) The Annual Report and Reference Handbook published by the American Board of Medical Specialties.
>
> (C) Is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

42 C.F.R § 412.105(f)(1)(i)(ii)(c).

Research rotations and resident leave time when taken during research rotations

Since the inception of the Medicare program, Congress has allowed the cost of training physicians based on the premise that ". . . these activities enhance the quality of care in an institution."[3] In 1983, Congress recognized that teaching hospitals have indirect operating costs that would not be reimbursed under the prospective payment system or by the DGME payment methodology and authorized an additional payment known as the IME payment to hospitals with GME programs. 42 U.S.C. § 1395ww(d)(5)(B). Specifically, the IME payment compensates teaching hospitals for the higher-than-average operating costs that are associated with the presence and intensity of residents' training in an institution but which cannot be specifically attributed to, and does not include, the costs of residents' instruction. The IME adjustment attempts to measure teaching intensity based on the ratio of the hospital's full-time equivalent interns and residents to beds. *Id*. Thus, the IME payment amount is based, in part, on the number of intern and resident full-time equivalents participating in a provider's GME Program.

For fiscal year 2000, the year at issue, the regulation governing IME reimbursement was codified at 42 C.F.R. § 412.105(f), and states in pertinent part:

> (1) For cost reporting periods beginning on or after July 1, 1991, the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> > (i) The resident must be enrolled in an approved teaching program...
> >
> > (ii) ... the resident must be assigned to one of the following areas:
> >
> > > (A) The portion of the hospital subject to the prospective payment system.
> > >
> > > (B) The outpatient department of the hospital.
>
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting in patient care activities under an approved medical residency training program is counted towards the determination of full-time equivalency if the criteria set forth at § 413.86(f)(4) are met.

[3] H.R. Rep. No. 213, 89th Cong., 1st Sess., 32 (1965). *See also* Medicare Payment Advisory Commission (MEDPAC) *Report to the Congress Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals* at 4 (Aug. 1999) (Provider Exhibit P-51).

42 C.F.R. § 412.105(f)(1)(i)-(ii)(C).

Effective October 1, 2001, CMS amended the Medicare regulations governing the IME payment to exclude all time spent by residents in research not involving the care of a particular patient:

> The time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable.

42 C.F.R. § 412.105(f)(1)(iii)(B).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Henry Ford Hospital (Provider) is a not-for-profit, acute care teaching hospital located in Detroit, Michigan. The Provider included DGME and IME FTEs on its cost report for fiscal year ending (FYE) December 31, 2000. National Government Services, LLC (Intermediary)[4] issued an NPR and adjusted the as-filed DGME and IME FTEs to its audit findings.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 - 405.1840 (2008).[5] The Provider was represented by Ronald S. Connelly, Esquire, of Powers, Pyles, Sutter & Verville, P.C. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' STIPULATIONS:

The Provider and Intermediary stipulated to the following pertinent facts[6]:

1. When calculating the Provider's payment for indirect medical education ("IME") payments pursuant to 42 U.S.C. § 1395ww(d) and 42 C.F.R. § 412.105, the Intermediary has not agreed to allow 8.1534 full-time equivalent residents ("FTEs") attributable to time spent conducting research. A summary schedule of the resident rotations comprising these 8.1534 IME FTEs is at Attachment A.

2. When calculating the Provider's payments for IME and for direct graduate medical education ("DGME") pursuant to 42 U.S.C. § 1395ww(h) and 42 C.F.R. § 413.86 (2000), the Intermediary has not agreed to allow 4.5874 IME FTEs and 3.0453 weighted DGME FTEs attributable to time spent by residents in the following medical training programs: C.S. Livingood, Movement Disorders, Cerebrovascular Disease/Stroke, and Cross Sectional Imaging. A summary schedule of the resident rotations comprising these 4.5874 IME FTEs and 3.0453 weighted DGME FTEs is at Attachment B.

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[4] National Government Services, LLC was previously known as United Government Services, LLC.

[5] As to the issue regarding FTEs enrolled in unaccredited programs, the Board majority has elected to take jurisdiction under 42 U.S.C. § 1395oo(d). *See*, Findings of Fact, Conclusions of Law and Discussion at page 9 of this decision for a complete discussion of the Board majority's opinion on the jurisdictional matter.

[6] Stipulation of the Parties signed September 17, 2009.

3. The Provider submitted with its supplemental position paper documentation in support of the FTEs identified in paragraphs 1 and 2. After reviewing these documents, and based upon further discussions and submissions by the Provider, the Intermediary has determined as follows:

a. The IME FTEs identified in paragraph 1 represent time spent by residents as part of an approved teaching program as defined in 42 C.F.R. §412.105(f)(i)(1) (2000).

b. The IME FTEs identified in paragraphs 1 and 2 represent time that the residents spent while they were assigned either to areas of the Provider subject to the prospective payment system or to outpatient departments of the Provider.

c. The DGME FTEs identified in paragraphs 1 and 2 represent time that the residents spent while working in the hospital complex.

d. No resident included in the DGME and IME FTEs identified in paragraphs 1 and 2 was counted as more than one FTE.

e. Of the DGME FTEs identified in paragraph 2, Lubomira Scherschun and Bogdan Iliescu were in their initial residency periods as defined in 42 C.F.R. §413.86(g) (2000), and Paul Harris, Vladislav Jankulov, Shilpa Kashyap, Dragos Mihalia, Nilolaos Papamitsakis, and Mark Zwirin were not in their initial residency periods as defined in 42 C.F.R. §413.86(g) (2000).

f. The Intermediary does not dispute the Provider's claim that all foreign medical graduates whose time is included in the DGME and IME FTEs identified in paragraphs 1 and 2 passed the Foreign Medical Graduate Examination in the Medical Sciences (Part I and Part II) ("FMGEMS") prior to January 1, 2000.

g. For each of the residents whose time is included in the DGME and IME FTEs identified in paragraphs 1 and 2, the Provider has submitted all information required by 42 C.F.R. §413.86(*i*) (2000) and 42 C.F.R. § 412.105(f)(2) (2000).

h. The IME FTEs identified in paragraph 1 represent time spent by residents in educational research that did not involve the direct care of individual patients.

i. The DGME and IME FTEs identified in paragraph 2 represent time spent by residents in programs that were not accredited during the Provider's fiscal year ending December 31, 2000.

4. The parties agree that the sole issue preventing inclusion of the IME FTEs identified in paragraph 1 is whether educational research that does not involve the care of individual patients must be included in the IME FTE count.

5. The parties agree that the sole issue preventing inclusion of the DGME and IME FTEs identified in paragraph 2 is whether the residents were enrolled in an approved training program as defined by 42 C.F.R. § 413.86(b), (f)(1)(sic) (2000) and 42 C.F.R. § 412.105(f)(i)(1)(sic) (2000).

6. The Provider has withdrawn its claim for DGME and IME reimbursement of residents in the following programs: Neuro-Oncology, Ophthalmic Plastic and Reconstructive Surgery, Retina, Cornea and External Disease, Neuro-Ophthalmology, and Breast Imaging. The Provider submitted at Exhibit P-47 of its supplemental position paper documentation supporting

reimbursement under Medicare Part B for the services of these residents. The Intermediary agrees to review the Provider's documentation at Exhibit P-47, and any additional documents furnished by the Provider at the Intermediary's request, and to determine the Provider's entitlement to payment pursuant to 42 C.F.R. §415.202 (2000).

7. The Provider also submitted at Exhibit P-47 of its supplemental position paper documentation supporting reimbursement under Medicare Part B for the services of the residents identified in paragraph 2. If a final administrative or judicial decision determines that any of these residents was not enrolled in an approved training program during FY 2000, the Intermediary agrees to review the Provider's documentation at Exhibit P-47, and any additional documents furnished by the Provider at the Intermediary's request, and to determine the Provider's entitlement to payment pursuant to 42 C.F.R. § 415.202 (2000).

Issue #1 – FTEs attributable to rotations by residents in certain unaccredited training programs

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly denied FTEs for residents training in one or more of the following subspecialty training programs: C.S. Livingood Research Fellowship, Movement Disorders Fellowship, Cross Sectional Imaging Fellowship and Cerebrovascular Disease/Stroke program. The Provider argues that although these programs were not accredited by a national organization, they were all "approved programs" as defined by the regulations at 42 C.F.R. § 413.86(b) and 42 C.F.R § 412.105(f)(1)(i)(B).[7]

The Provider asserts that the C.S. Livingood Fellowship counts towards certification in dermatology because the program increases a resident's knowledge and experience in an important aspect of dermatology. The Provider submitted a printout from the American Board of Medical Specialties' (ABMS) Medical Specialties Plus database demonstrating that the resident at issue was certified in dermatology, and thus the training did count for certification.[8]

Next, the Provider asserts that the Movement Disorders Fellowship counts towards certification in neurology because the resident trained for three years in neurology from 1997 to 2000, which was followed by a one year training in the Movement Disorders Fellowship from July 1, 2000 through June 30, 2001.[9] The year after the resident completed the fellowship, he was certified in neurology; thereby demonstrating that the training in the Movement Disorders Fellowship counted towards certification.

As to the Cross Sectional Imaging Fellowship program, the Provider asserts this program counts towards certification in vascular and interventional radiology (VIR). The Provider contends that one of the residents at issue was certified in VIR after completing the program.[10] The Provider argues that the Intermediary's refusal to include the FTEs at issue here solely because the resident did not train in VIR prior to entering the Cross Sectional Imaging program is an

[7] Provider's Supplemental Position Paper at 40; Tr. at 15.
[8] Provider's Exhibit P-39 at 410.
[9] Provider's Exhibit P-40 at 431-435.
[10] Provider's Exhibit P-46 at 757.

unreasonable construction of the regulation and should be rejected. [11] The Provider acknowledged that other residents in the Cross Sectional Imaging program did not receive certification in VIR. However, as the Board held in a prior decision for the same Provider, a program may be approved even though the residents do not obtain certification.[12] The Provider asserts that the Cross Sectional Imaging program met the regulatory requirement for an approved program, participation in which "may count" toward certification. Thus the program itself is an approved program, and all residents in the program should be included in the DGME and IME counts.

The Provider contends that the Cerebrovascular Disease/Stroke program may count towards a subspecialty certification in vascular neurology. The Provider advises that the program, became accredited by the ACMGE as of July 1, 2005 and re-named Vascular Neurology.[13] The American Board of Psychiatry and Neurology (ABPN) created a grandfathering provision in which unaccredited training in vascular neurology counts toward certification through 2009.[14] Based on the grandfathering provision, the training during the fiscal year (FY) 2000 in the unaccredited Cerebrovascular Disease/Stroke program counts towards certification in vascular neurology. Thus, the program meets the regulatory requirements of an approved program.

Finally, to the extent that it is determined that any of the Provider's fellowship training programs at issue are not approved and consistent with 42 C.F.R. § 415.202, the Provider contends that it should be reimbursed on a reasonable cost basis under Medicare Part B for the services furnished by the fellows in unapproved programs. The Provider advises that it had submitted documentation to substantiate Part B reimbursement for additional residents. In addition the Intermediary has agreed to review this documentation if a final administrative judicial decision determines that any of the above programs are not Medicare approved programs.[15]

INTERMEDIARY'S CONTENTONS:

The Intermediary contends that the Provider has failed to establish that any of the time spent training in the unaccredited fellowship programs could or would count toward certification in an approved program.[16] Specifically, the Intermediary contends that the time the resident spent in the C.S. Livingood Fellowship did not count towards becoming board eligible in dermatology; and at the time another resident was enrolled in the Movement Disorders Fellowship program, he

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[11] Tr. at 140-41, 144-45.

[12] *Henry Ford Hospital v. Blue Cross Blue Shield Association/National Government Services*, Dec. No. 2008-D34, Medicare & Medicaid Guide (CCH) ¶82,109(PRRB Sept. 12, 2008) ("*Henry Ford I*"), *aff'd in part, rev'd in part*, Medicare & Medicaid Guide (CCH) ¶82, 212 (CMS Administrator 2008). (The Administrator affirmed the Board's decision as to the unapproved residency programs, and reversed the Board's decision as to the inclusion of IME research time in FTE counts and orders remanding to the Intermediary for consideration of the Provider's claims for reasonable cost reimbursement under Medicare Part B), *aff'd in part , rev'd in part sub nom*. *Henry Ford Health System v Sebelius*, 680 F. Supp 2d 799 (E.D.Mich. Dec. 30, 2009) ("*Henry Ford Health System*"). On appeal to the federal district court, the Provider declined to appeal the unapproved residency programs issue. See, *Henry Ford Health System* at 803.

[13] Tr. at 41.

[14] Provider's Exhibit P-78, P-80.

[15] Stipulation No. 7.

[16] Intermediary's Supplemental Position Paper at 31; Tr. at 24.

was already qualified for certification in neurology.[17]

Next, the Intermediary asserts that the Provider's Cross Sectional Imaging Fellowship program may not count towards certification in VIR because the program fails to satisfy the requirements contained in the Green Book. According to the Green Book, a one year VIR fellowship must be completed prior to the practice year, or the additional year of training.[18] The Intermediary advised this requirement was informally confirmed by the American Board of Radiology.[19] The Intermediary argues that for the year at issue, none of the residents enrolled in the Cross Sectional Imaging program had completed the mandatory one year VIR fellowship prior to enrollment in the Cross Sectional Imaging program. The Intermediary notes that the Provider indicated one resident enrolled in the program completed a fellowship in VIR at another hospital, and was later certified in that subspecialty.[20] The Intermediary maintains that there is nothing in the record to support a claim that the resident's time spent in the Provider's Cross Sectional Imaging program was used to qualify for certification in VIR. Consequently the Provider has failed to establish that the program would count toward certification in an approved program.

Finally, the Intermediary argues the Provider's Cerebrovascular Disease/Stroke program does not count towards certification in vascular neurology because during the time of the training there was no certification in existence in which the program could be counted. The ABMS did not approve vascular neurology as a subspecialty until 2003, and it was not accredited by the ACGME until July 2005, all of which was subsequent to the period under appeal.[21] The Intermediary recognizes that the ABMS approval included a grandfather clause through 2009; however, during the cost reporting period at issue neither the residents nor the hospital would have known that the fellowship would later be accredited and that the training could be counted toward certification under a grandfather clause. The Intermediary advises that in the prior decision, *Henry Ford I*, the Board affirmed the Intermediary's position.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions and stipulations and the evidence contained in the record, the Board finds and concludes the following:

Before determining the merits of the unaccredited training programs at issue, the Board must determine whether it has jurisdiction. The Board majority finds the Provider has the right to hearing on the unaccredited program issue under 42 U.S.C. § 1395oo(a).

The Board's jurisdiction is established under 42 U.S.C. § 1395oo(a). It provides, in relevant part:

[17] Tr. at 111, 116 – 17; Provider's Exhibit P-39 at 410 and Exhibit P-40 at 435.
[18] Intermediary's Supplemental Position Paper at 29; Tr. at 120-124.
[19] Intermediary's Exhibit I-16.
[20] Tr. p. 124-25; Exhibit P-46 at 757.
[21] Intermediary's Supplemental Position Paper at 27; Tr. at 117-19. Upon accreditation in July 2005, the Cerebrovascular Disease and Stroke program was re-named "Vascular Neurology."

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider -
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

At the hearing, the witness for the Intermediary testified that the Provider did not claim the unaccredited programs when filing its 2000 cost report. Instead, the issue was first presented during the appeals process when the Provider appealed a routine adjustment to its FTE count.[22] At that time, the Provider presented documentation related to the programs and FTEs at issue in this case. The Intermediary reviewed the claims[23] and made a determination, allowing some of the FTEs.[24] The Provider appealed the Intermediary's decision to not allow some of the FTEs claimed. Based on these circumstances, the Board finds that the Intermediary's final determination was made after consideration of the claims by the Intermediary and included a determination not to allow the claims in dispute here. Therefore, the Board concludes it has jurisdiction over the issue in this case as it was part of the final determination. The Board also notes that the Intermediary did not question the Board's jurisdiction over this issue.

As to the merits of the issue, the Board finds and concludes that the Intermediary's exclusion of FTEs attributable to rotations by residents in the unaccredited C.S. Livingood Research Fellowship, Movement Disorder Fellowship and Cross Sectional Imaging program was proper. The Board also finds and concludes the Intermediary's exclusion of the FTEs attributable to rotations by residents in the unaccredited Cerebrovascular Disease/Stroke Fellowship was improper.

42 C.F.R. § 413.86(b) and 42 C.F.R. § 412.105(f)(1)(i) both contain the language "may count towards certification" in describing an approved teaching program. As the Board explained in *Henry Ford I*, inherent in the broadly worded regulations is the requirement of proof that the training program would count toward certification. The Board agrees that the regulation does not require a resident to obtain certification as a prerequisite to count the unaccredited training, but that does not exempt the Provider from having to document that the training would indeed count toward certification. Absent evidence of acceptance from the certifying body, the Provider would have to furnish alternative documentation to support its assertion that the training could be counted toward certification.

The Board finds that the Provider has not met the burden of proof to show that the C.S. Livingood Research Fellowship, Movement Disorder Fellowship and Cross Sectional Imaging

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[22] Tr. at 174 – 75.
[23] Tr. at 176.
[24] Intermediary's Supplemental Position Paper at 25.

program could count towards certification. Specifically, for the C.S. Livingood Research Fellowship, there is nothing in the record to show that the time spent in the program was required to obtain certification in dermatology. Simply because a resident was certified in dermatology after completing the program does not prove that the certification was dependent on the Fellowship.[25] The Board notes that for the Movement Disorder Fellowship, accreditation is required prior to entering the Fellowship program, and hence the fellowship could not count towards certification.[26] For Cross Sectional Imaging program, the subspecialty did not exist in the fiscal year at issue and hence the time spent in that program should not be counted.[27] The Board concludes that the time attributed to the C.S. Livingood Research Fellowship, Movement Disorder Fellowship and Cross Sectional program were properly excluded from the FTE count.

While the aforementioned programs do not satisfy the requirements of 42 C.F.R. § 413.86(b) and 42 C.F.R. § 412.105(f)(1)(i), the Board notes that the Provider's fellowship programs do meet the requirements of a non-approved educational program under 42 C.F.R. §415.202. As such, the costs incurred (salary and salary-related fringe benefits) are allowable. The Intermediary is to review the Provider's documentation contained in Provider's Exhibit P-47 and any additional documents furnished by the Provider at the Intermediary's request, and to determine the Provider's entitlement to payment pursuant to 42 C.F.R. § 415.202.[28]

As to the Cerebrovascular Disease/Stroke program (re-named Vascular Neurology), the Board finds the Provider has furnished sufficient documentation to show the program does qualify as a Medicare approved program. Specifically, the record demonstrates that the program was accredited in 2005. Also the ABPN created a grandfathering provision in which unaccredited training in vascular neurology counted towards certification through 2009. By virtue of the grandfathering provision, the training in the Provider's Cerebrovascular Disease/Stroke program may count toward certification for the year under appeal. As such, the time attributed to the program should be included in the Provider's FTE count.

Issue # 2- Exclusion of time spent by residents in research when counting IME FTEs.

PROVIDER'S CONTENTIONS:

The Provider contends that based upon the pertinent statute and controlling regulation, the time residents spend performing research activities as part of an approved residency program should be included in the IME FTE calculation.[29] While 42 U.S.C. §1395ww(d)(5)(B) provides specific instructions for calculating the IME adjustment, it does not exclude time spent by residents performing research activities. The regulation at 42 C.F.R. § 412.105(f) provides more specific rules for counting FTE residents for IME. These rules require that residents who work in non-hospital settings be engaged in patient care activities in order to be included in the IME FTE resident count. The Provider further asserts that the issue has been litigated in the federal courts,

[25] Tr. at 111-112.
[26] Provider Exhibit P-40 at 422.
[27] Tr. at 120.
[28] Stipulation No. 7.
[29] Provider's Supplemental Position Paper at 15-16.

and that the courts have upheld the Board's decisions that the IME research time is properly included in the IME FTE calculation.[30]

The Provider also contends that the August 1, 2001 amendment to the IME regulation cannot be viewed as a clarification of existing policy since it establishes new recordkeeping requirements; i.e., time spent by residents performing patient and non-patient care activities while assigned to a research rotation. This amendment cannot be applied to the cost reporting period included in this appeal because retroactive rule making is prohibited.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. §§ 413.5 and 413.90 specifically preclude any payment of Medicare funds for research that is not directly related to treating particular patients. As such, any time spent by residents performing research activities that are not directly related to the care of patients is excluded from the resident count. The Intermediary contends that Agency guidance contained in Provider Reimbursement Manual (PRM) §2405.3 also reflects that a resident must not be included in the IME count if "[t]he individual is engaged exclusively in research."[31] The Intermediary argues that the Agency reiterated the manual section in August 2001, in its response to comments regarding IME payment issues.[32] The Intermediary contends that the Provider has failed to show that any of the disallowed resident research time was directly related to patient care; thus, the time may not be included in the IME FTE count.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

After consideration of Medicare law and guidelines, the parties' contentions and stipulations and the evidence contained in the record, the Board finds and concludes that the Intermediary's removal of IME FTEs related to a research rotation was improper.

The Board addressed the IME resident research issue in several cases, including one involving this Provider.[33] In all these cases the Board found that the regulation in effect during the subject cost reporting periods did not exclude research time from the IME FTE resident count, nor did it require resident time to be related to patient care. In pertinent part, the regulation states:

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[30] *Henry Ford Health System v. Sebelius* at 806; *University of Chicago Medical Center v. Sebelius*, 645 F.Supp.2d 648 N.D. Ill (Aug. 3, 2009); *University Medical Center Corp. v. Leavitt*, 2007 WL 891195 (D. Ariz. March 21, 2007); *Riverside Methodist Hospital v. Thompson* (S.D. Ohio 2003) ("*Riverside*") [2003-2 Transfer Binder] Medicare and Medicaid Guide CCH ¶ 301,341.

[31] Intermediary's Supplemental Position Paper at 11.

[32] Intermediary's Supplemental Position Paper at 12. *See*, [66 Fed. Reg. 39823, 39896 - 99 (August 1, 2001). (A copy of the Fed. Reg. is contained at Intermediary's Exhibit I-8)].

[33] *Henry Ford I; University of Chicago Hospitals and Clinics v. Blue Cross Blue Shield Association/United Government Services*, PRRB Dec. No. 2007-D57 (August 8, 2007), *rev'd*, CMS Administrator (October 2007), *rev'd, University of Chicago Medical Center*, 645 F. Supp. 2d, 648 (N.D. Ill. Aug 3, 2009) (Provider's Exhibit P-79); *University Medical Center (Tucson, Ariz.) vs. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Arizona*, PRRB Dec. No. 2005-D36 (April 12, 2005), *rev'd*, CMS Administrator (June 7, 2005); *rev'd, University Medical Center Corp. v. Leavitt* 2007 WL 891195 (D. Ariz., 2007) ("*University Medical Center*") (Provider's Exhibit P-65).

> (1) . . . the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program…
>
> (ii) In order to be counted, the resident must be assigned to one of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
>
> (B) The outpatient department of the hospital.
>
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting…

It is undisputed that the residents at issue in this case were enrolled in an approved GME program and that they worked in either the portion of the Provider's facility subject to PPS or an outpatient area. Consequently, the Intermediary's adjustment removing them from the count was improper.

The Board notes that its finding is consistent with other court decisions, including one involving this Provider. In *Henry Ford Hospital Systems*, the district court held that the Secretary could not exclude residents engaging in educational research from the Hospital's IME resident count under the 1996 version of 42 C.F.R. § 412.105(g)(1)(ii). [34] Next, in *Riverside Methodist Hospital v. Thompson*, the court concluded that "the [IME] regulation as it was written at the time in question, does not by its plain language contain any requirement that the time spent by residents had to be spent in direct patient care in order to be counted." [35] Lastly, in *University Medical Center Corp.*,[36] the court concluded:

> The [pre-2001] regulation is not ambiguous, and, when considered in context with the historical intent of both the regulation and its governing statute, it is evident that all time spent by residents in research and other scholarly activities while they are "assigned to" the Hospital must be included when determining the Hospital's resident count for purposes of calculating the IME payment.

Additionally, the Board finds that the 2001 amendment to the IME rule excluding non-patient care research time from the resident count represents a change in policy that cannot be applied retroactively to the cost reporting periods in issue. As the court in *Riverside* explained, the IME regulation is clear in that the time spent by residents performing non-patient care related activities is not excluded from the resident count, and "if the Secretary desires to include a new requirement regarding excludable time, it must be done by amendment, and in compliance with the

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[34] *Supra*, n. 12.
[35] *Riverside Methodist Hospital v. Thompson* ,(S.D. Ohio 2003) [2003-2 Transfer Binder] Medicare and Medicaid Guide CCH ¶ 301,341. ("*Riverside*") (Provider's Exhibit P-62).
[36] *University Medical Center Corp.* at 9.

necessary administrative procedures for amending regulations (as was done in 2001 to exclude time spent by residents conducting research)."

DECISION AND ORDER

Issue #1 - FTEs attributable to rotations by residents in certain unaccredited training programs

The Intermediary's adjustments excluding FTEs attributable to rotations by residents in C.S. Livingood Research Fellowship, Movement Disorder Fellowship and Cross Sectional Imaging unaccredited training programs were proper. Further, this issue is remanded to the Intermediary to determine the Providers' entitlement to payment for these three programs under 42 C.F.R. §415.202.

The Intermediary's adjustment excluding FTEs attributable to rotations by residents in the Cerebrovascular Disease/Stroke program was improper. The issue is remanded to the Intermediary to recalculate the FTE count attributable to rotations by residents in the Cerebrovascular Disease/Stroke program. The Intermediary's adjustments are modified.

Issue #2 – Exclusion of time spent by residents in research when counting IME FTEs

The Intermediary's adjustments reducing the Provider's IME FTE resident count for the time spent by residents in research that was required by the residents' approved medical residency program were improper. The issue is remanded to the Intermediary to recalculate the IME adjustment by incorporating the time spent by residents in research activities that were part of their approved medical residency training program.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: SEPTEMBER 30, 2010