PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D9

PROVIDER –
Welch Community Hospital
Welch, West Virginia

Provider No.: 51-0086

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Palmetto GBA

DATE OF HEARING –
August 1, 2013

Cost Reporting Period Ended –
June 30, 2005

CASE NO.: 07-2350

INDEX

ISSUE:

Was the Intermediary's adjustment to reclassify Rural Health Clinic visits associated with contracted physicians, and the associated full-time equivalents ("FTEs"), from cost report Worksheet M-2, line 9 to Worksheet M-2, line 1, correct?

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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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 organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[3] Each 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").[4] 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.[5]

Rural Health Clinics ("RHCs") were established by the Rural Health Clinic Service Act of 1977 ("RHCSA")[6] to address an inadequate supply of physicians serving Medicare beneficiaries in underserved rural areas, and to increase the utilization of nurse practitioners ("NP") and physician assistants ("PA") in these areas. RHCs have been eligible to participate in and furnish RHC services under the Medicare program since March 1, 1978.

42 U.S.C. §§ 1395x(aa)(1) and (2) provides definitions for RHCs and RHC services. RHCs are defined as facilities that are engaged primarily in providing outpatient services that are typically furnished in a physician's office. RHC services are defined as:

- Physician services;
- Services and supplies furnished incident to a physician's services;

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.
[6] Pub. L. No. 95-210, 91 Stat. 1485 (1977).

- NP, PA, certified nurse midwife ("CNM"), clinical psychologist ("CP"), and clinical social worker ("CSW") services; and
- Services and supplies furnished incident to an NP, PA, CNM, CP, or CSW services.

RHC services may also include nursing visits to homebound individuals furnished by a registered professional nurse or a licensed professional nurse when certain conditions are met.

Exercising the discretion granted to the Secretary under the controlling statute, the Secretary has establish payment rates for qualified primary and preventive health services furnished to Medicare beneficiaries.[7] Specifically, payment to provider-based RHCs for Medicare-covered RHC services is made by means of a provider-specific all-inclusive rate for each visit set annually by the intermediary for the relevant cost reporting period.[8] The encounter rate is generally subject to an upper payment limit[9] and includes covered services provided by an RHC physician, physician assistant, nurse practitioner, clinical nurse midwife, clinical psychologist, clinical social worker or visiting nurse; and related services and supplies.[10] The term "visit" is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered.[11]

For purposes of setting the all-inclusive encounter rate, allowable costs are the costs actually incurred by the RHC that are reasonable in amount and necessary and proper to the efficient delivery of services.[12] Typical allowable costs include, to the extent reasonable:

- Compensation for the services of physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers compensated by the RHC;
- Compensation for the duties that a supervising physician is required to perform;
- Costs of services and supplies incident to the services of a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or clinical social worker;
- Overhead costs, including RHC administration, costs applicable to the use and maintenance of the RHC facility, and depreciation costs;
- The costs of physician services furnished under agreements with the RHC; and
- If the RHC is located in an area with a shortage of home health agency ("HHA") services, the cost of visiting nurse services and related supplies furnished.[13]

These costs are limited to amounts that are reasonable. Pursuant to the authority established under 42 C.F.R. § 405.2468(d)(2), CMS has provided screening guidelines for Intermediaries to

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[7] *See* RHCSA § 1 (adding 42 U.S.C. § 1395l(a)(3)); 47 Fed. Reg. 54163-03 (Dec. 1, 1982). *See also* Medicare Benefit Policy Manual, CMS Pub. No. 100-02 ("MBPM 100-02"), Ch. 13, § 10.1.
[8] 42 C.F.R. §§ 405.2462, 405.2464, 405.2466, 405.2468.
[9] *See* 42 C.F.R. § 405.2468(e); 57 Fed. Reg. 24961 (June 12, 1992).
[10] *See* 42 C.F.R. § 405.2463(a).
[11] 61 Fed. Reg.14640, 14657, (Apr. 3, 1996). *See also* 42 C.F.R. § 405.2463(a).
[12] *See* 42 C.F.R. § 405.2401(b).
[13] *See* Medicare Claims Processing Manual, CMS Pub100-04 ("MCPM 100-04"), Ch. 9, § 40. *See also* 42 C.F.R. § 405.2468(b).

test the reasonableness of an RHC productivity and establish a per visit payment limit.[14] Payments for services are subject to screening guidelines to test the reasonableness of the productivity of the clinic's health care staff. These productivity screening guidelines are applied to staff for RHC services furnished both at the clinic's site and in other locations. CMS set forth these productivity screening guidelines as follows in the preamble to the Medicare Claims Processing Manual, CMS Pub. No. 100-04 ("MCPM 100-04"), Chapter 9, § 40.3:

> Payments for [RHC] services are subject to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for RCH/FQHC services furnished both at the clinic/center's site and in other locations. They are as follows:
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> - At least 4,200 visits per year per full time equivalent physician *employed* by the clinic/center;
> - At least 2,100 visits per year per full time equivalent physician assistant or nurse practitioner employed by the clinic/center; or
> - If staffing levels consist of various combinations of physicians and nurse practitioners or physician assistants, a combined screening approach may be used. [15]

The productivity standards are used to help determine the average cost per patient for Medicare reimbursement in the RHC.

At the end of its cost reporting period, the RHC must report to the Intermediary its actual costs incurred and the total number of visits for RHC services during the period.[16] In the case of a provider-based RHC, the cost and statistical data is reported in the Worksheet M series of the hospital cost report, in this instance Form CMS 2552-96. These Worksheets contain the statistical data and other information necessary to enable the Intermediary to calculate a cost-per-visit, apply the RHC productivity standards outlined above, and apply the RHC payment cap.

Through the mechanics of the cost report, the Intermediary adjusts the payments made during the cost reporting period to equal 80 percent of the net Medicare cost. The net Medicare cost is Medicare covered visits multiplied by the lesser of the adjusted cost per visit or the maximum payment rate per visit less beneficiary deductibles. To this amount is added 100 percent of the Medicare reasonable cost of pneumococcal vaccine and its administration, less interim payments made to the clinic during the reporting period, plus reimbursable bad debts to determine the total amount due to, or from, the Medicare program.[17]

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[14] *See* MCPM 100-04, Ch. 9, § 40. *See also* 42 C.F.R. § 405.2468(c).
[15] (Emphasis added) (established by Transmittal 1 (Oct. 1, 2003)). *See also* 57 Fed. Reg. 24961, 24967 (June 12, 1992).
[16] *See* MCPM 100-04, Ch. 9, §§ 20.4 and 30.1.
[17] 57 Fed. Reg. at 24964.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Welch Community Hospital ("Provider") is a 108 bed acute care hospital located in Welch, West Virginia. The Hospital contains a hospital-based nursing facility and a hospital-based RHC. The cost reporting period in question is the Provider's fiscal year ending June 30, 2005 ("FY 2005"). For FY 2005, the Provider's designated intermediary was National Government Services, Inc. ("Intermediary").[18]

The Provider contracted emergency room and RHC physician services through a private physician group (Kelly Medical) to provide coverage of those areas during hours of operation. The Provider reported the total number of RHC visits for these contracted physicians on line 9 – Physician Services Under Agreements of Worksheet M-2 of Form CMS 2552-96. During its review of the cost report the Intermediary reversed this handling by removing the visits from line 9. It then reclassified the visits, and related physician FTEs, to line 1 of Worksheet M-2.[19]

On January 4, 2007, the Intermediary issued an NPR for FY 2005.[20] On January 29, 2007, the Provider requested a reopening to correct the Intermediary's handling of the contracted physician visits and FTEs for FY 2005.[21] On March 2, 2007, the Intermediary denied the reopening request.[22] Subsequently, on June 18, 2007, the Provider filed a timely appeal of the Intermediary's determination to the Board.[23]

The Provider was represented by its Chief Financial Officer, Carla Parent. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider argues that it appropriately reported contracted physician RHC visits on line 9 of Worksheet M-2 of Form CMS 2552-96. It points to the cost report instructions for that line in place at the time the cost report was prepared. The instructions read in part: "Enter the number of visits furnished to facility patients by physicians under agreement with you. *Physician's services under agreements with you are (1) all medical services performed at your site by a physician who is not the owner or an employee of the facility...*"[24] The Provider contends that, as the contracted physicians at issue are neither owners nor employees of the hospital or RHC, the associated visits were appropriately reported on line 9 of Worksheet M-2.[25]

The Provider goes on to argue that the Intermediary's reclassification of the contracted physician RHC visits, along with the associated FTEs, to line 1 of Worksheet M-2, inappropriately subjects the contracted physicians to the RHC productivity standards. The Provider contends that this reclassification contradicts the screening guidelines as set forth in the

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[18] In April 2011, the Provider's designated intermediary was changed to Palmetto GBA (MAC Jurisdiction 11).
[19] Provider's Final Position Paper at 2.
[20] Provider Exhibit P-1.
[21] Provider Exhibit P-8.
[22] Provider Exhibit P-9.
[23] Provider Exhibit P-2.
[24] (Emphasis added.)
[25] Provider's Final Position Paper at 4 (emphasis added).

Medicare Claims Processing Manual, Pub. No. 100-04 ("MCPM 100-04"), Chapter 9, § 40.3 which states that the guidelines are applied to health care staff *employed* by the clinic.[26]

Additionally, the Provider argues that the Intermediary's basis for its adjustments was not based on any regulatory authority, but rather a CMS representative's interpretation of the intent of the regulations, namely that the exemption from productivity standards for contracted physicians is intended for specialists whose services are not available within the RHC and are brought in on a limited basis or to whom patients are referred. The Provider notes that the staffing and physician responsibilities as described in 42 C.F.R. § 491.8 make no reference to physician services under agreement being defined as specialists contracted on an as needed basis who provide specialized services not available at the RHC, nor do the cost report instructions related to Worksheet M-2, line 9.[27]

The Intermediary contends that its adjustment to reclassify the contracted physicians' visits and FTEs was proper and consistent with the regulation at 42 C.F.R. § 491.9 – Provision of Services. This regulation states:

> (c) *Direct services* – (1) *General.* The clinic or center staff furnishes those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at the entry point into the health care delivery system. These include medical history, physical examination, assessment of health status, and treatment for a variety of medical conditions.

It continues to say:

> (d) *Services provided through agreements or arrangements.* (1) The clinic or center has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to its patients, including:
> (i) Inpatient hospital care;
> (ii) Physician(s) services (whether furnished in the hospital, the office, the patient's home, a skilled nursing facility, or elsewhere); and
> (iii) Additional and specialized diagnostic and laboratory services that are not available at the clinic or center.[28]

The Intermediary relies on guidance received in a CMS email that states that the RHC productivity standards apply to all physicians working for the clinic on an ongoing regular basis to furnish services to clinic patients within the four walls of the RHC, regardless of whether or not the physicians are under a traditional employment arrangement or under a contractual arrangement.[29]

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[26] Provider's Final Position Paper at 3-4 (emphasis added).
[27] Provider's Final Position Paper at 4-6.
[28] Intermediary's Final Position Paper at 3.
[29] Intermediary Exhibit I-1.

The Intermediary argues that the services provided by the contracted physicians were within the RHC and appear to be those types of services that are commonly and frequently furnished in a physician office. As such, the visits and FTEs associated with the contracted physicians should be reported on line 1 of Worksheet M-2 of Form CMS 2552-96, thus subjected to the productivity screens on the cost report.[30] The Intermediary contends that only those physician services purchased on "a limited and intermittent basis" are exempt from the productivity standards as set forth in the regulations.[31] Visits associated with those types of services should be reported on line 9 of Worksheet M-2 of Form CMS 2552-96.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider properly reported the RHC visits associated with contracted physicians on line 9 of Worksheet M-2 of CMS Form 2552-96.

42 C.F.R. § 405.2468(d)(2) provides CMS with the authority to issue productivity screening guidelines. As explained below, the Board's plain reading of the productivity screening guidelines and cost reporting instructions that were in effect during the time at issue shows that physician services under agreement are not subject to the productivity standards when such physicians are neither owners nor employees of the RHC.

The Board finds that the cost report instructions for Worksheet M-2 of Form CMS 2552-96 clearly specify that the number of visits furnished to facility patients by physicians under agreement should be reported on line 9 of the Worksheet. The instructions further emphasize that "Physician's services under agreements with you are . . . ***all*** *medical services performed* at your site *by a physician who is not the owner or an employee of the facility.*"[32] In this case, the record establishes that none of the physician services under agreement that are at issue were by a physician who was either an owner or employee of the Provider.

Likewise, the Board finds that the RHC productivity screening guidelines as described in the Federal Register in 1982 and 1992[33] and set forth in the MCPM 100-04, Chapter 9, § 40.3 clearly specify that the guidelines are to be applied to healthcare staff "*employed*"[34] by the clinic.

Finally, the Board notes that the Intermediary in its Final Position Paper cites to an email from CMS to suggest that "department policy states that only those physician services purchased on a 'limited and intermittent basis' are exempt from the productivity standard."[35] However, during the time at issue, neither the cost report instructions nor the manual provisions cited above contained any guidance specifying application of the productivity standards to contracted physicians if the physician services under agreement are furnished at a certain frequency, *e.g.*,

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[30] Intermediary's Final Position Paper at 4.
[31] Intermediary's Final Position Paper at 3.
[32] (Emphasis added.)
[33] *See* 47 Fed. Reg. at 54165; 57 Fed. Reg. at 24967.
[34] (Emphasis added).
[35] Intermediary Final Position Paper at 3 (citing to Intermediary Exhibit 1 which is an email exchange occurring in July 2005).

such services are provided on a regular ongoing basis as opposed to being provided on a limited and/or intermittent basis.

Subsequent to the time at issue, the Board notes that, on January 31, 2013, CMS revised Chapter 13 of the Medicare Benefit Policy Manual, CMS Pub. No. 100-02 ("MBPM 100-02") to add productivity standards in § 70.4. In particular, CMS added the following language that was effective March 1, 2013:

> Physician services under agreements are not subject to the productivity standards. Instead of productivity limitation, purchased services are subject to a limitation on what Medicare would otherwise pay for the services (under the Physician Fee Schedule), in accordance with 42 C.F.R. 405.2468(d)(2)(v).[36]

The policy statement is consistent with how the Board has interpreted and applied the manual guidance that was in effect during the time period at issue.

On November 22, 2013, CMS again revised the discussion of physician services under agreement in MBCP 100-02, Chapter 13, § 70.4 as follows:

> Physician services *that are provided on a short term or irregular basis* under agreements are not subject to the productivity standards. Instead of productivity limitation, purchased services are subject to a limitation on what Medicare would otherwise pay for the services (under the Physician Fee Schedule), in accordance with 42 C.F.R. 405.2468(d)(2)(v). *Practitioners working in a RHC or FQHC on a regular, ongoing basis are subject to the productivity standards, regardless of whether they are paid as an employee or independent contractor.*[37]

The above policy change is consistent with what the Intermediary cited in its final position paper. However, this policy change was effective on January 1, 2014 well after the time period at issue. Accordingly, it is not applicable to this case.

DECISION AND ORDER:

The Board finds that the Provider properly reported the RHC visits associated with contracted physicians on its as-filed cost report for FY 2005. The Intermediary's adjustments are reversed.

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[36] MBPM, Transmittal 166 (Jan. 31, 2013).
[37] MBPM, Transmittal 173 (Nov. 22, 2013) (Emphasis in original).

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAY 29 2014