PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D93

PROVIDER -
Mercy Hospital Medical Center
Des Moines, Iowa

Provider No. 16-0083

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Iowa

DATE OF HEARING-
August 5, 1998

Cost Reporting Period Ended -
June 30, 1990

CASE NO. 92-0591

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ISSUE:

Was the Intermediary's allocation of the Provider's physician billing costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Hospital Medical Center ("Provider") is an acute care hospital located in Des Moines, Iowa. The Provider timely filed its Medicare cost report for the fiscal year ended June 30, 1990. In its filed cost report, the Provider allocated total costs of $170,768 to a non-allowable physician billing cost center.[1] The Provider had established this cost center to exclude from allowable costs the nonallowable costs of rendering billing services for some of its hospital-based physicians. On October 25, 1991, Blue Cross and Blue Shield of Iowa ("Intermediary") issued a Notice of Program Reimbursement in which it allocated $938,904 to this same cost center.[2]

On January 24, 1992, the Provider appealed the Intermediary's determination regarding the allocation of physician billing costs to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect is approximately $20,732.

The Provider was represented by Joanne B. Erde, P.A., Steel Hector & Davis. The Intermediary was represented by Bernard M. Talbert, Esquire, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it allocated costs to its nonallowable physician billing cost center in accordance with Medicare's long standing step-down methodology. The Medicare regulations at 42 C.F.R. § 413.24 and the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1")
§§ 2306 and 2310 require a provider to allocate its costs based upon the step-down methodology, unless it uses a more sophisticated method in which case it would need intermediary approval. The Provider maintains that neither it nor the Intermediary is suggesting that it used a more sophisticated methodology. Specifically, the Provider fragmented its Administrative and General ("A&G") costs and, in doing so, maintained a separate Patient Accounting Department cost center, which contained all the direct costs of its billing activities. The Provider asserts that it maintained records that reflected the direct costs of providing billing services for both hospital services and physician services.

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1 Provider's Position Paper, p. 4.

2 Provider's Exhibit P-3.

The Provider states that it then allocated these actual direct costs based upon a gross revenue statistic, i.e., physician revenue to total revenue. As a result, the portion of the Patient Accounting Department direct costs for rendering billing services to its physicians was excluded from allowable costs. In order to do a full step-down of the indirect costs, it treated its nonallowable physician billing cost center as it would any other cost center. Based upon the Worksheet B step-down cost finding, it allocated A&G based upon a cost statistic, i.e., the ratio of the costs accumulated in the cost center to total costs. Thus, its cost report treatment of non-allowable physician billing costs complied with the well accepted and required step-down method for allocating costs.

The Provider maintains that the Intermediary's claim that it did not comply with the step-down methodology requirements is erroneous and unsupported by the regulations and the Manual. The Intermediary bases its arguments upon a memo issued in 1987 by Blue Cross of Iowa which, the Intermediary asserts, was dictated per instructions from the Health Care Financing Administration ("HCFA"). The memo, however, is inconsistent with the regulations and the Manual in that it requires permission from the intermediary to use the step-down method.[3]

The Provider points out that the HCFA instructions cited by the Intermediary, as found in a HCFA memorandum, admitted that, at that point, Medicare reimbursement policy for the treatment of provider costs for physicians' billing was 'not currently manualized.'[4] HCFA's policy on reimbursement of physician billing costs, which was 'manualized' in PRM-1 § 2110.4 and adopted in July 1996, provides, in pertinent part:

> Unallowable physician billing costs must be identified by you and offset against your total direct and indirect billing costs. Reasonable estimates of unallowable physician billing costs, inclusive of direct and indirect costs, as well as representative portion of overhead, are acceptable, subject to review and approval by your servicing Medicare fiscal intermediary. . . .In situations where it is impractical to segment the billing staff, estimates of physician billing costs may be based upon ratios of physician bills processed to total bills processed by the billing staff applied to total billing costs. . . .

HCFA Pub. 15-1 § 2110.4.

The Provider argues that the methodology it followed in determining the indirect costs associated with its physician billing activities is much closer to this procedure than that used by the Intermediary in making its adjustment. In any event, when the events of the instant

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[3] Provider's Exhibit P-6.

[4] Provider's Exhibit P-7. Although the Provider gives a date of June 15, 1987 for the memorandum, the copy at Exhibit P-7 bears no date.

case occurred, the regulations and manual instructions required the step-down methodology absent intermediary approval of a more sophisticated approach. In fact, the Intermediary did expressly authorize the step-down approach for allocating physician billing costs when in 1985, through audit adjustment number 50, it required the Provider to allocate its costs for billing physician services in this manner.[5] It has consistently used the step-down methodology ever since.

The Provider points out that the Intermediary has acknowledged, by using the same methodology for allocating direct billing costs, that the step-down method is correct. Both the Provider and the Intermediary have applied the ratio of physician revenue to total revenue in allocating these costs. The Intermediary, however, contradicts itself by asserting that allocating Patient Account Department costs based upon the ratio of physician revenue to total revenue does not adequately identify direct costs and cannot be used as a basis for allocating the remaining A&G. The Intermediary's approach, which is to divide A&G costs by the sum of total costs and physician revenue, is not calculated properly nor is it supported by the Medicare rules and regulations. The A&G unit cost multiplier is calculated by dividing A&G costs by total costs.

The Provider asserts that the Intermediary's allocation methodology based upon a hybrid unit cost multiplier is inconsistent with all Board decisions on this matter. The Provider cites American Medical International, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 95-D21, February 13, 1995, Medicare and Medicaid Guide ("CCH") ¶ 43,080; Humana Hospital-Sharpstown (Houston, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 93-D38, May 14, 1993, Medicare and Medicaid Guide ("CCH") ¶ 41,441; Humana Hospital-Greenbrier (Roncerverte, W.Va.) v. Mutual of Omaha Insurance Company, PRRB Dec. 93-D39, May 14, 1993, Medicare and Medicaid Guide ("CCH") ¶ 41,442; Humana Hospital-St. Lukes Bluefield (Bluefield, W. Va.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 93-D40, May 14, 1993, Medicare and Medicaid Guide ("CCH") ¶ 41,443; Humana Hospital--Garland (Garland, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 92-D15, February 20, 1992, Medicare and Medicaid Guide ("CCH") ¶ 40,084; and Humana Hospital--Beaumont (Beaumont, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 92-D16, February 20, 1992, Medicare and Medicaid Guide ("CCH") ¶ 40,084. The Board has repeatedly held that the use of a hybrid unit cost multiplier to allocate A&G to a nonallowable physician billing cost center is incorrect. In each of these cases, the Board concluded that a determination by the intermediary of the provider's billing costs by multiplying the A&G unit cost multiplier by physician revenue was improper and unreasonable in light of the direct costs of each provider's billing department. This conclusion also applies to the instant case. The result of the Intermediary's approach, which allocated $938,904 to the Provider's nonallowable physician billing cost center, was an allocation of 72 percent of the direct billing costs to this cost center, or 35 percent of the fully allocated billing department costs. The Intermediary's approach is unreasonable and

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[5] Provider's Exhibit P-4.

inaccurate in light of the fact that physician revenue is only 5.39 percent of total hospital revenue.[6]

The Provider further argues that in each of these decisions, the Board determined that each provider's calculation, which was substantially the same as the Provider's calculation, was more accurate and appropriate. In the instant case, the direct and indirect billing costs allocated to the nonallowable physician billing costs were 1.4 percent of physician revenue. Similarly, on the as-filed cost report, the billing costs allocated to billing for hospital revenue, was 1.3 percent of hospital revenue.[7] Thus, the Provider's allocation was consistent, accurate, and reasonable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it has a responsibility under Section 1861(v)(1)(a) of the Social Security Act and 42 C.F.R. § 413.9(b)(1) to prevent the cross-subsidization of Medicare and non-Medicare beneficiaries. On August 27, 1984, the Intermediary issued to its staff a memoradum concerning HCFA Form 1500 Billing costs. The memorandum stated that "HCFA has instructed us to remove the cost of billing on the 1500 form from provider costs."[8] The memorandum also states:

> In addition, reference is made to that portion of the October 1, 1982 Federal Register which states although these services (office space, billing, collection) are furnished by the provider to the physician, they are related to the physician's services to individual patients, not provider services to patients. The services are reimbursed as physician, not provider services. Therefore, the costs incurred by the provider in performing these functions are not allowable costs for provider reimbursement. However, we believe that some providers are including these costs in their cost reports as if they were allowable costs.

Id.

The Intermediary further cites a HCFA Central Office memorandum that stated as follows:

> Although not currently manualized, Medicare reimbursement policy relative to the treatment of provider costs for physicians' fee-for-service billing for physician services rendered to individual provider patients is generally the same as that described in sub-section 2108.10, Treatment of Provider Costs

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6 Provider's Position Paper, p. 14.

7 Provider's Position Paper, pp. 14-15.

8 Intermediary Exhibit I-3.

> Related to the Provision of Physician Services to Non-provider Patients, of the Provider Reimbursement Manual (PRM), HCFA Pub. 15-1. All direct and indirect costs incurred by the provider in connection with such services should be identified and deducted from provider costs in determining allowable costs for Medicare reimbursement purposes. Where the actual provider costs relating to these billing services cannot be identified, reasonable estimates must be made of costs incurred by the provider. If the provider receives revenue for such services, the estimated costs may not be less than such revenue.

Undated HCFA memorandum.

The Intermediary contends that after discussions with the Kansas City Regional Office of HCFA on a method for determining physician billing costs, it advised providers of two acceptable approaches. The preferred method was to apply the unit cost multiplier times the net physician revenues billed by the provider. Only through application of the unit cost multiplier to all other A&G components could it be assured that all direct and indirect costs related to physician billing services were removed. This is the approach it used on the Provider's cost report. The second acceptable method was a full step-down cost finding offset, which required prior approval and an identification of all A&G costs related to physician billings.[9]

The Intermediary contends that while it appears that the Provider used a full step-down cost finding offset, it did not comply with the requirements for this method. First, the Provider did not request nor did the Intermediary approve use of the step-down methodology. Second, the Provider failed to accurately identify A&G component costs applicable to the fragmented cost centers. Therefore, the Intermediary avers that it has no basis for assuming that the Provider's approach is more reasonable for allocating the A&G cost center than the unit cost multiplier.

The Intermediary contends that it is aware of two of the prior Board cases cited by the Provider, Humana Hospital--Garland (Garland, Tex.) v. Mutual of Omaha Insurance Company and Humana Hospital--Beaumont (Beaumont, Tex.) v. Mutual of Omaha Insurance Company. Neither applies to the Provider. In those cases, the intermediary's offset adjustment was approximately 19 percent of the physicians' revenue amount whereas in this situation the offset is only 7.9 percent. Second, the 7.9 percent offset is in line with the 7 percent billing cost factor used by HCFA in constructing the Certified Registered Nurse Anesthesiologist fee schedule.[10]

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[9] Intermediary's Position Paper, p. 9 and Exhibit I-5.

[10] Intermediary's Position Paper, pp. 11 and 12.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.9(b)(1)	-	Cost Related to Patient Care - Definitions - Reasonable Cost

3. Program Instructions - Provider Reimbursement Manual Part I (HCFA Pub. 15-1):

§ 2306	-	Cost Finding Methods
§ 2310	-	More Sophisticated Methods
§ 2110.4	-	Physician Billing Costs

4. Cases:

American Medical International, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 95-D21, February 13, 1995, Medicare and Medicaid Guide ("CCH") ¶ 43,080.

Humana Hospital-Sharpstown (Houston, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 93-D38, May 14, 1993, Medicare and Medicaid Guide ("CCH")
¶ 41,441.

Humana Hospital-Greenbrier (Roncerverte, W.Va.) v. Mutual of Omaha Insurance Company, PRRB Dec. 93-D39, May 14, 1993, Medicare and Medicaid Guide ("CCH")
¶ 41,442.

Humana Hospital-St. Lukes Bluefield (Bluefield, W. Va.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 93-D40, May 14, 1993, Medicare and Medicaid Guide ("CCH") ¶ 41,443.

Humana Hospital--Garland (Garland, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 92-D15, February 20, 1992, Medicare and Medicaid Guide ("CCH") ¶ 40,084.

Humana Hospital--Beaumont (Beaumont, Tex.) v. Mutual of Omaha Insurance Company, PRRB Dec. No. 92-D16, February 20, 1992, Medicare and Medicaid Guide ("CCH") ¶ 40,084.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the controlling laws, regulations and program instructions, the facts in this case, the parties' contentions, and the evidence in the record, finds and concludes that there was no authority for the Intermediary's method of allocation.

The Board finds that there was agreement by both parties on the establishment of a non-reimbursable cost center. There was also agreement on the allocation of the direct patient billing costs. The disagreement focused primarily on the allocation of the A&G overhead.

The Board finds no authority for the Intermediary's method of allocation, especially the hybrid unit cost multiplier, nor for the Intermediary's mixing of revenue and cost in its computation. The Board disagrees with the Intermediary's claim that prior approval was needed for the Provider's allocation method. The Board further finds that the Provider used the appropriate stepdown method in accordance with the regulations, and the documentation provided by the Provider was adequate.

DECISION AND ORDER:

The Intermediary's allocation of physician billing costs was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

Date of Decision: September 11, 1998
FOR THE BOARD:

Irvin W. Kues
Chairman