PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2001-D4

PROVIDER -
Otis Bowen Center For Human Services
Warsaw, Indiana

Provider No. 15-4014

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminaStar Federal

DATE OF HEARING-
September 13, 2000

Cost Reporting Period Ended -
June 30, 1995

CASE NO. 98-0627

INDEX

ISSUE:

1. Was the Intermediary correct in its disallowance of Provider component hours for provider-based physicians.

2. Was the Intermediary correct in its adjustments to total charges and Medicare charges for the clinic cost center.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Otis R. Bowen Center for Human Services, Inc. ("Provider") is a psychiatric hospital located in Warsaw, Indiana. The Provider offered both inpatient and outpatient psychiatric services. It was certified on March 14, 1979, and has participated in the Medicare program since that date. AdminaStar Federal (AIntermediary@) issued a Notice of Program Reimbursement (ANPR@) for the fiscal year ended June 30, 1995 (AFY 95"). The NPR included the disputed adjustments stated above. The Provider appealed these adjustments to the Provider Reimbursement Review Board (ABoard@). The Provider=s appeal request meets the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Provider is represented by Mr. Gregory M. Bradley of Bradley & Associates, Inc. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

Issue 1- Provider Component Hours

Facts

The Provider completed Worksheet A-8-2 of its Medicare cost report for FY 95 in which it claimed 1192 provider component hours for provider-based physicians (Medicare Part A). The Intermediary reviewed the data submitted on Worksheet A-8-2 of the Provider's "as-filed" cost report. As a result of its review, no provider component remuneration for the provider-based physicians was allowed. All remuneration for the Provider's provider-based physicians was treated as the professional component of physician remuneration. As a result, the Intermediary reduced the Provider=s claimed cost by $92,469. This resulted in a reduction in Medicare reimbursement of approximately $11,000.

PROVIDER=S CONTENTIONS:

The Provider contends that a portion of the provider-based physician hours are Part A hours. The Provider had three physicians that performed provider services. These physicians' contracts are included as Provider Exhibits 5, 8, and 12. The contracts clearly show that the three physicians are providing more than direct patient care. The Provider accumulated the physicians' hours for the cost reporting period. The Provider's narratives describing the physicians' time is included in Exhibit 3. The Provider's summaries of the physicians' time are included in Exhibit 4. The time summaries are signed by the physicians, and President/CEO, and Vice President, Fiscal Division, of the Provider.

The Provider notes that one of the physicians, Dr. Yee, is the Medical Director for the Provider.[1] He performed various duties for the Provider which included patient services, administrative duties, supervision of staff, travel time and vacation/sick time. Dr. Yee has reported mileage of 7,018 miles.[2] Based on an average of fifty miles per hour, Dr. Yee's mileage converts to 140 hours. Dr. Yee also used 182.5 hours of vacation time and 32 hours of sick time during this cost reporting period.[3] Based on the Provider's records, Dr. Yee has 355 Part A hours.

The Provider further notes that Dr. Khoga's, contract is included as Exhibit 8. Per that contract, he performed various duties for the Provider which included patient services, administrative duties, supervision of staff, continuing education, travel time and vacation/sick time. Dr. Khoga's mileage reports support his travel time.[4] Based on an average of fifty miles per hour, Dr. Khoga's mileage converts to 48 hours. He also used 148 hours of vacation and 99 hours of sick time during the cost reporting period.[5] He attended 40 hours of continuing education during the cost reporting period.[6] Based on the Provider's information, Dr. Khoga had 335 Part A hours.

The Provider observes that the third physician, Dr. Kalapatupa, is an independent contractor for the Provider. His contract is included as Exhibit 12. The majority of Dr. Kalapatupa's time is related to patient services. However, he is also paid for his travel time which is not direct patient care time. Dr. Kalapatupa's contract specifically states that he is to be paid for two hours of travel each week. Dr. Kalapatupa submitted requisitions for reimbursement of his travel time.[7] Dr. Kalapatupa has 104 Part A hours.

The Provider also contends that there is not a material change in the percentage of Part A remuneration from the prior year. In the prior year the Part A remuneration was $80,316 or 16.85% of total remuneration. In the current year the Part A remuneration is $92,469 or 19.77% of total remuneration.

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1 See Provider Exhibit 5.

2 See Provider Exhibit 6.

3 See Provider Exhibit 7.

4 See Provider Exhibit 9.

5 See Provider Exhibit 10.

6 See Provider Exhibit 11.

7 See Provider Exhibit 13.

Based on the above, the Provider believes that the Board should modify the Intermediary's adjustments and allow 794 Part A hours.[8]

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it reviewed the Provider's documentation in support of the provider component hours claimed for the three physicians. The Provider presented copies of Exhibit 3 of the Form HCFA-339[9] to the Intermediary as support for the provider component hours. No other documentation was offered in support of these hours. The Intermediary determined that this documentation was inadequate to support the provider component hours. Accordingly, it made an adjustment to treat all of the remuneration related to the three physicians as professional component rather than split the physician compensation between the professional and provider components.

The Intermediary notes that in reviewing Dr. Yee's contract[10] it determined that he was contracted to provide full-time psychiatric services and medical director responsibilities for the Provider. Under the terms of the contract, Dr. Yee provided both patient care, or professional (Medicare Part B) services and administrative, or provider (Medicare Part A) services. The contract specified that Dr. Yee received a salary for providing psychiatric services to patients of the Provider and fulfilling the duties of the Medical Director position. The Provider, however, has been unable to provide adequate documentation to support its allocation of physician compensation.

The Intermediary observes that without adequate documentation to support its allocation of physician compensation, all of the Provider's physician compensation should be treated as direct patient care. 42 C.F.R. ' 415.60 (previously designated as 42 C.F.R. ' 405.481) and HCFA Pub. 15-I, ' 2182.3 stipulate that certain recordkeeping requirements be met by the Provider. Specifically, 42 C.F.R. ' 415.60(g)(1) requires that the Provider:

> . . . maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or the carrier.

Id.

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8 See Provider Exhibit 14.

9 See Intermediary Exhibit No. 1

10 See Intermediary Exhibit 5.

The Intermediary notes that in a similar case, the Board supported the intermediary's adjustment to disallow physician compensation because inadequate documentation was provided to the Intermediary. In the case of Central Medical Center and Hospital Pittsburgh, Pa. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 91-D13, January 4, 1991, Medicare and Medicaid Guide (ACCH@) & 39,019, the Board found that the provider did not maintain adequate time records in accordance with 42 C.F.R. ' 405.481(g). Similarly, the Intermediary would ask that the Board also require that adequate documentation be presented by the Provider in this case.

In reviewing the contracts for Dr. Khoga[11] and Dr. Kalapatapu[12] the Intermediary determined that these physicians provided psychiatric services. Dr. Khoga was contracted to provide full-time psychiatric services for the Provider, while Dr. Kalapatapu, an independent contractor, was contracted to provide part-time psychiatric services. The contracts for these two physicians specified that only direct patient care services were to be provided to patients of the Provider. The provision of no other services on behalf of these two physicians was enumerated in their contracts.

The Intermediary notes that the Provider has requested that certain documented hours be counted as Part A, or provider component hours, for the allowability of a portion of compensation related to the three physicians. Namely, the Provider requests the vacation/sick time for Drs. Yee and Khoga be counted as Part A hours. The Provider has also requested that the time Dr. Khoga spent attending continuing education be included in the Part A hours. Finally, the Provider has requested that the mileage reported by all three physicians be converted to hours and these hours be included in the Part A hour count. The Intermediary asserts that vacation/sick time and continuing education are not identified as services to patients in providers (Part B) or as services to providers (Part A) as defined in HCFA Pub. 15-I, '' 2182.4 and 2182.6. These activities do not constitute Part A or Part B services rendered to a provider. Vacation/sick time and continuing education are defined in HCFA Pub. 15-I, ' 2144 as fringe benefits.

The Intermediary further observes that as fringe benefits, the amounts paid to the physicians relative to vacation /sick time and continuing education time are part of a physician's total compensation. As such the pay for vacation/sick time and continuing education time should be split based on the physician's time devoted to Part A and Part B activities. The fringe benefits, as part of the physician's total compensation, should not be handled any differently than salary. The physician's total compensation should be allocated between Part A and Part B activities as supported by adequate documentation offered by the Provider. Since the Provider could not provide adequate documentation to support the split in the physicians' compensation, all compensation was treated as 100% Part B.

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[11] See Intermediary Exhibit 9.

[12] See Internediary Exhibit 10.

The Intermediary contends that the contracts for Drs. Yee and Khoga[13] do not address reimbursement for mileage or travel time. Only the contract for Dr. Kalapatapu[14] addressed compensation for travel time. Dr. Kalapatapu provided only part-time psychiatric services for the Provider under the terms of the contract. As such, all compensation paid to Dr. Kalapatapu for services rendered in accordance with the contract should be treated as Part B service costs.

Issue 2 - Clinic Charges

Facts:

The Provider submitted its "as-filed" cost report with physician charges included in total charges for certain cost centers reported on Worksheet C of the Medicare cost report to allocate costs between inpatient and outpatient. The Provider had also included the physician charges in Medicare charges for the same cost centers reported on Worksheet D of the Medicare cost report to apportion allowable costs to Medicare. The Intermediary had made an adjustment to both total and Medicare charges. The Medicare charges were adjusted to reflect amounts per Medicare=s Provider Statistical and Reimbursement Report (APS&R@). The Intermediary also made an adjustment to total charges for the relevant cost centers to be consistent with the Medicare charges. Thus, the Intermediary reduced the total clinic charges by $342,527 and Medicare charges by $122,325. This resulted in a reduction in Medicare reimbursement of approximately $7,000.

PROVIDER=S CONTENTIONS:

The Provider contends that the cost report was correct as submitted. Per the cost report instructions in the Provider Reimbursement Manual, the cost report may be submitted including or excluding physician charges. The Provider Reimbursement Manual, Part II ' 2813.1 states:

> [I]f the total charges for all patients for a department include a charge for the provider-based physician's (APHB@) professional component, then total and program charges used on Worksheets D and D-4 and Supplemental Worksheets D-2, D-3, and D-6 must also include the PBP's professional component charge in order to correctly apportion costs to the program. Similarly, when total charges on Worksheet C, Part I, for a department are for provider services only, charges on

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13 See Intermediary Exhibits 5 and 9.

14 See Intermediary Exhibt 10.

> Worksheets D and D-4 and Supplemental Worksheets D-2, D-3, and D-6 must also include provider services only.

Id.

Per these cost report instructions, Worksheets C and D must be filed consistently, using either both net or gross physician charges. However the instructions do not state that one method must be used. The Provider believes that it is the Provider's option to file these worksheets either net or gross of physician charges.

The Provider also contends that the clinic charges on the filed cost report were handled consistently with the prior cost report. It is unreasonable for the Intermediary to accept the Provider's methodology in one year but not in the following period.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Provider did submit its "as-filed" cost report for the current year using gross physician charges. Total charges reported on Worksheet C of the cost report included physician charges for the adults & pediatrics and clinic cost centers. The Medicare charges for the Clinic cost center reported on Worksheet D of the cost report included physician charges. The Intermediary made an adjustment to Medicare charges on Worksheet D to reflect the PS&R which does not include physician charges. With the Intermediary's adjustment to the Medicare charges, an inconsistency existed between the Medicare charges and total charges. To eliminate the inconsistency, the Intermediary made an adjustment to eliminate the physician charges from total charges.

The Intermediary notes that the Provider argues that its "as-filed" cost report was correct as submitted. The Provider contends that the cost report may be submitted with or without physician charges. Either way, total charges and Medicare charges must be consistent. Therefore, if total charges are filed with physician charges, Medicare charges must also include physician charges and vice versa. The Intermediary concurs with this argument. The Provider has the option to file its cost report either with (gross) or without (net) physician charges. In light of this, the Intermediary has proposed to modify its adjustments. The Intermediary has offered to reverse its adjustments to total charges on Worksheet C to include total physician charges. The Intermediary has also offered to adjust the Medicare charges to include paid physician charges. Medicare charges on Worksheet D of the cost report reflect paid charges. The physician charges should be consistent with the Medicare charges. Therefore, the intermediary proposes to include the paid physician charges with the Medicare charges. This should eliminate any distortions in the apportionment of costs to the Medicare Program.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

'' 405.1835-.1841	-	Board Jurisdiction
' 415.60 (previously designated ' 405.481), et al	-	Allocation of Physician Compensation Costs

Program Instructions - Provider Riembursement Manual - HCFA Pub. 15-1:

' 2144	-	Fringe Benefits
' 2182.3	-	Allocation Of Physician Compensation
' 2182.4	-	Conditions For Reasonable Charge Payment For "Physicians' Services" To Patients In Providers
' 2182.6	-	Conditions Of Payment For Costs Of Physicians' Services To Providers

HCFA Pub. 15-II:

' 2813.1	-	Computation of Ratio of Cost to Charges

3. Cases:

Central Medical Center and Hospital Pittsburgh, Pa. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 91-D13, January 4, 1991, Medicare & Medicaid Guide (ACCH@) & 39,019.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties= contentions and evidence finds and concludes as follows.

Issue No. 1 - - Provider Component Hours

The Board finds that two of the physicians which the Provider requested to have part of their hours considered Medicare Part A hours were employees of the Provider. The third physician whose hours

were likewise requested to be considered Part A hours was an independent contractor. The contracts for the physicians were included in evidence and supported the Provider=s argument that the above physicians did perform some administrative duties. However, there was insufficient documentary support to allow an allocation of the physicians= compensation as Part A costs. There were no allocation agreements in evidence. The Board does note that HCFA Forms 339 were placed into evidence. However, these were not supported by actual time studies or other pertinent evidence to establish that the services stated in the HCFA 339s were actually performed by the physicians.

The Board observes that the time claimed by the Provider for sick and vacation pay, as well as continuing professional education time, are not direct time for determining Part A physician costs. That time is considered indirect time and the cost related thereto is considered a fringe benefit under HCFA Pub. 15-1 ' 2144. These costs are added to the physicians= salary to arrive at total physician compensation. This compensation is then allocated to Medicare Part A/B based on relevant hours performed by the physicians.

Regarding travel costs, the Board observes that neither Drs. Yee nor Khoga=s contracts provided for reimbursement for travel. Therefore, the Intermediary=s adjustment for travel time for these physicians was correct. Further, the Board notes that Dr. Yee was the Provider=s medical director and that Medicare Part A costs should be allowed. However, as noted above, evidence cannot be verified regarding the amount of time spent by Dr. Yee for that activity.

Issue No. 2 - - Clinic Charges

The Board finds that both parties agree that HCFA Pub. 15-II ' 2813.1 applies to the Provider=s situation, i.e., the Provider has the option of using either provider charges or provider/physician charges to allocate clinic costs to Medicare. It also finds that the Intermediary is willing to modify its position and allow the use of Provider/Physician charges to allocate costs. Since the Provider=s methodology complies with both the regulatory and program policy intent in the above PRM section, and since the Provider has consistently used the provider/physician charges in prior periods, the Board concludes that the Provider may do so in FY 95. Therefore, the Intermediary=s adjustment is reversed.

DECISION AND ORDER:

Issue No. 1 - - Provider Component Hours

No hours or related costs can be allocated to the Provider Part A physician component due to the lack of supporting evidence. The Intermediary=s adjustment is affirmed.

Issue No 2 - - Clinic Charges

The Provider properly used provider/physician charges to allocate and apportion costs to Medicare. The Intermediary=s adjustment is reversed.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: November 02, 2000

FOR THE BOARD

Irvin W. Kues
Chairman