PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D35

PROVIDER -
University Hospital
Cincinnati, OH

Provider No. 36-0003

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminaStar Federal, Inc.

DATE OF HEARING-
April 25, 2001

Cost Reporting Period Ended -
June 30, 1992

CASE NO. 96-0343

INDEX

ISSUES:

Issue 1: Was the Intermediary's reclassification of the Provider's allocation of certain administrative salaries and fringe benefits from various ambulatory service areas back to A & G costs proper?

Issue 2: Was the Intermediary's emergency room physician billing revenue against emergency room expense rather than A & G expenses proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

University Hospital, ("Provider") formerly Cincinnati General Hospital, is a general, short-term, 619 bed hospital which includes a Rehabilitation Unit (Subprovider II) and Psychiatric Unit (Subprovider I). The Provider was formerly operated by the University of Cincinnati, a state university, but effective January 1, 1997 it was reorganized as a not-for-profit corporation known as University Hospital, Inc. During the cost reporting year in question and historically, University Hospital has been a significant hospital provider in the Greater Cincinnati area of acute and general health care services to Medicare, Medicaid, Welfare, and other medically indigent patients.

The Provider has timely appealed to the Provider Reimbursement Review Board ("Board") the issues noted above and included as adjustments in the Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 1992, issued by AdminaStar Federal, Inc ("Intermediary") on June 30, 1995. The Provider's appeal request meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated Medicare reimbursement effect of the above noted adjustments is $211,463 for issue No. 1 and $15,518 for issue No. 2.[1] All other issues have either been withdrawn or administratively resolved. The Provider is represented by Peter L. Cassady, Esq. of Beckman, Weil, Shepardson and Faller, LLC. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

Issue 1- Allocation of Administrative Salaries and Fringe Benefits

Facts

[1] Provider Position Paper at 2 & 6; Intermediary Position Paper at 2-3.

The Intermediary reclassified the Provider's allocation of certain administrative salaries and fringe benefit costs from various ambulatory service areas back to the Administrative and General Cost Center. The Provider had reported in its cost report the salaries, fringe benefits, and other direct costs (computer supplies, stationery, etc.) of certain employees who work in the ambulatory patient care areas in two different cost centers: Ambulatory Services Administration (Cost Center No. 4170) and Outpatient Registration (Cost Center No. 4173). The costs charged to Cost Center No. 4170 were allocated to various ambulatory patient care areas based on time estimates provided to the Provider by the persons involved. The costs that had been charged to Cost Center No. 4173 were allocated to various ambulatory patient care areas based on the ratio of the number of clinic visits over the total number of clinical visits. The Provider believes that the Intermediary reclassified all of the costs from 4170 and 4173 back to the Administrative and General Cost Center because the Provider did not have time studies for each of the involved employees.[2] The Provider contends that this resulted in a portion of these costs being allocated inappropriately to inpatient expenses.

The Intermediary's adjustment states "To reverse A-6 reclass code V, since this costs should be allocated thru the B-1's"[3]

The Provider chose two cost centers, Ambulatory Services Administration (Cost Center, 4170) and Outpatient Registration (Cost Center, 4173), originally grouped with other A&G costs, to be allocated to various outpatient ancillary service cost centers. The Provider contends that Ambulatory Services Administration and Outpatient Registration are "unique cost centers" used only by outpatients and these costs should be reflected only in outpatient ancillary cost centers.

PROVIDER'S CONTENTIONS:

The Provider contends that for many years, it has charged these exact same costs associated with outpatient administrators to the Ambulatory Services Administration Cost Center and the Outpatient Registration Cost Center and then allocated the costs to particular ambulatory patient care areas. In fact, the Provider contends that it did this in its PPS base year, with the Intermediary's approval, which gave rise to the Hospital's DRG rates.

With respect to the costs (salaries, fringe benefits and other direct expenses) allocated by the Provider to the Ambulatory Services Administration Cost Center (No. 4170), the Provider's method of allocation is as follows: Provider Exhibit 2A details the allocation of salaries and benefits for five employee categories from the Ambulatory Services Administration to twenty-two separate clinical areas. They total $395,614. The allocation is based on the employees' time estimates of their own work on behalf of ambulatory services.

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[2] Provider Position Paper at 3.

[3] Intermediary Position Paper at 2; Intermediary Exhibit I-1, Adj. # 17.

With respect to the other direct expenses (non-salary expenses) allocated to Cost Center No. 4170, Provider Exhibit 2C details coded expenses in the left hand column which total $92,501. These expenses are computer supplies, stationery, brochures and publications, furnishings, equipment repair, other equipment, and rental equipment. The Provider contends that these expenses were ascertained from actual invoices generated by the clinics to which they were allocated.
The Provider contends that the costs allocated to Cost Center No. 4173 ($185,052; See Provider Exhibit 2B), were incurred by employees who were fully and solely employed in Outpatient Registration which has nothing to do with Inpatient Registration. All costs associated with these employees were allocated to the clinics based on the ratio of the number of clinic visits over the total number of clinical visits. The Provider believes that to require time studies from these employees is simply not reasonable.

Nevertheless, the Provider notes that the Intermediary reclassified all of these expenses back to the Administrative and General Cost Center which resulted in having some of these costs allocated to inpatient expenses which resulted in the Provider losing $211,463 in Medicare reimbursement. The Provider argues that these costs have nothing to do with the inpatient side of the Hospital and yet the Intermediary forced this illogical result by reclassifying these costs merely because the Provider lacks time studies to demonstrate that a person working in Outpatient Registration spends his or her time solely on outpatient registration. The Provider maintains that the Intermediary's reclassification takes the technical requirement of having time studies and produces the absurd result of having these costs partially attributed to the inpatient side. It is the Provider's position that it is being punished for the lack of time studies which it believes is neither fair, reasonable, nor logical. The Provider contends that time studies should not be required of Outpatient Administrators when they spend 100% of their time on the outpatient side of the Provider's activities. The Provider asserts that to then reclassify the costs related to these employees and step them down so that they are, in part, allocated to inpatient, makes no sense. The Provider believes this is especially true since the Intermediary allowed this exact cost allocation to No. 4170 and No. 4173 for the Provider's PPS base year (1983).

The Provider contends that the Intermediary's argument about how it is selectively picking and choosing those "unique cost centers" that benefit Medicare reimbursement while ignoring cost centers that may be detrimental to Medicare reimbursement is a smoke screen. The Provider further contends that the Intermediary attempts to divert focus from the real issue that the costs associated with the involved employees are incurred on the outpatient side. The Provider maintains that the mere fact that the cost report accumulates these costs in the A&G cost center is irrelevant and is a mere weakness and inconsistency within the cost report itself. It is the Provider's primary contention that it has allocated these costs to the appropriate cost centers to reflect reality, they were incurred on the outpatient side. The Provider believes that to suggest that it had to make a written request to do what it had been doing for many years (since at least 1983, the Provider's PPS base year) is ludicrous.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that Inpatient Accounts (Account 4008) and I/P Business Office (Account 4010) are contained in A&G on Worksheet A of the cost report. According to the Intermediary, these accounts appear to be related 100% to inpatients. However, the Intermediary contends that the Provider makes no attempt to allocate the inpatient costs in a manner consistent with the way in which it is arguing outpatient costs should be allocated. According to Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1) §2313.1 (Intermediary Exhibit I -2), if the Provider elects to use its unique cost centers in lieu of the recommended cost centers on the cost reporting forms certain conditions must be met. One of the conditions is that the Provider's use of the unique cost centers will result in a more accurate cost finding. (§ 2313.1.C). The Intermediary contends that the Provider is selectively picking and choosing those "unique cost centers" that benefit Medicare reimbursement while ignoring those cost centers that may be detrimental to Medicare reimbursement. Also, § 2313.1 .D indicates that the Provider must make a written request to the Intermediary prior to the end of the cost reporting period in order to implement this election. The Intermediary contends that the Provider did not make this request.

In summary, the Intermediary believes it has properly reclassified these costs to A&G.

Issue 2: Emergency room physician billing revenue

Facts

According to the Intermediary, this adjustment was made to reconcile emergency room physician payments to amounts indicated under the contract for emergency room physicians. The Intermediary reduced emergency room costs by this reconciling amount. The Provider, however, believes that the amount of the adjustment should have been offset against Administrative & General costs rather than against emergency room costs.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly offset Emergency Room Physician Billing Revenue against Emergency Room Costs rather than Administrative and General Expenses. The Provider explains that as a service to its Emergency Room Physicians, it billed and collected fees for physician services. The Provider charged a fee for this billing service and offset this revenue against the Administrative and General Expenses. The Provider believes that the Intermediary adjusted this offset by offsetting the revenue against Emergency Room Costs.

The Provider contends that the revenue generated by providing a billing and collection service to its Emergency Room Physicians has nothing to do with the Emergency Room costs. The Provider maintains that the revenue was clearly generated by the Hospital's Patient Accounting area and not the Emergency Room. As such, it is the Provider's primary position that the revenue should definitely be an offset against its Administrative and General Expenses rather than the costs of the Emergency Room. The Provider asserts that the Emergency Room did not bill and collect Emergency Room Physician Fees and, therefore, the revenue retained by the Hospital in

performing this function should not be offset against the Emergency Room costs.

Intermediary's Contentions:

The Intermediary contends that the Provider included $2,570,750 of physician expenses in total emergency room costs. The intermediary points out that according to the Provider's prepared analysis of emergency room physician payments (See Intermediary Exhibit I - 3), the actual expense of the contracted amount should be $2,356,975. Thus, the Intermediary maintains that an adjustment of $213,775 should be made to adjust the expenses to agree with the amount under the contract.

The Intermediary notes that the Provider made this adjustment on its as-filed cost report (See Intermediary Exhibit I - 4). However, the original adjustment was made to the A&G cost center rather than the emergency department. The Intermediary believes that the Provider is mistaken in its position that the adjustment in question related to revenue received for billing services performed by Provider employees for provider physicians. The Intermediary contends that its adjustment corrects the Provider's original adjustment to reconcile emergency room expenses. Accordingly, the Intermediary respectfully asks that the Board uphold its adjustment.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

§§405.1835-.1841.	-	Board Jurisdiction

2. Program Instructions- Provider Reimbursement Manual, Part 1 (HCFA Pub. 15-1):

§2313.1et seq.	-	Use of Provider's Unique Cost Centers

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instruction, facts, parties' contentions and evidence finds and concludes as follows:

Issue 1- Allocation of Administrative Salaries and Fringe Benefits:

The Board finds that the record proffered by both parties is incomplete and neither party provided overwhelming evidence to support its position. The Board would have liked to have seen job descriptions for the various personnel costs being allocated, detailed time studies, support for the Provider's claim that the Intermediary had granted prior approval to change allocation methods, and an expansion on the Intermediary's argument to support its position that after the Provider allocated outpatient costs, the remaining costs in A & G were inpatient. Accordingly, the Board's decision on this issue is based on several assumptions and the paucity

of evidence contained in this extremely "thin" record.

The Board assumed that the salaries in question in account 4170 relate to clinic managers (departmental managers) and would be similar to the Provider's inpatient ancillary service managers. Also, with regard to account 4170, the Board finds that the Provider's argument that "other costs" were supported by invoices was not challenged by the Intermediary.
The Board finds that while the Provider's argument covered it's reasoning for costs being allocated to the various outpatient clinics from accounts 4170 (Ambulatory Services Administration) and 4173 (Outpatient Registration), the Intermediary was not entirely convincing that the balance of costs remaining in A & G after the allocation would be inpatient, and consequently, these costs would be allocated back to outpatient through the normal step-down process.

The Board believes, however, that standard Inpatient Registration costs were still accounted for in A & G costs. Therefore, a portion of these inpatient registration costs, comparable to outpatient registration costs that were pulled out of A & G and directly allocated to outpatient areas, would also be allocated through the step-down process back to the outpatient areas in question.

The Board concludes, based on the limited evidence presented, and on the above findings and assumptions, that the costs the Provider removed from "Other A & G" costs, charged to account 4170 and then directly allocated to specific outpatient clinic areas, were in fact outpatient costs. The Board further concludes that this is a more accurate method to allocate these costs. The Intermediary did not convince the Board that the Provider's direct allocation of these costs to account 4170 was improper.

The Board also concludes, based on the limited evidence presented, and on the above findings and assumptions, that the Outpatient Registration costs which the Provider directly allocated from account 4173 to various outpatient clinics, should be returned to "Other A & G" costs since these costs are similar to Inpatient Registration costs which reside here, and both costs should be stepped down through the normal process.

Issue 2: Emergency room physician billing revenue

As in Issue 1 above, the Board notes that the evidence contained in the record for this issue was also extremely "thin." The Board would have liked to have seen contracts for the ER physicians as well as documentation for the billing arrangements/fees between the Provider and the contractual ER physicians.

The Board finds that Intermediary Exhibit I-3 is a key piece of evidence to be used in evaluating this issue. This exhibit is an analysis of contractual emergency room physician expenses and compares the general ledger amounts to the contractual services log. The Board notes that the Intermediary made a reconciling adjustment between the amounts totaled in the general ledger column and the amounts totaled in the contractual services log column in this Exhibit.

While the Board understands the logic of the Provider's argument, there is no evidence in the record to support the argument. Accordingly, based on the evidence in the record, the Board concludes that the Intermediary's adjustment was correct.

DECISIONS AND ORDERS:

Issue 1- Allocation of Administrative Salaries and Fringe Benefits

The Intermediary's adjustment is modified. The Provider's direct allocation of outpatient costs from account 4170 (Ambulatory Services Administration) to various outpatient clinics is a more accurate method of allocation of these costs than the normal step down process. This portion of the Intermediary's reclassification adjustment is reversed. The Provider's direct allocation of outpatient costs from account 4173 (Outpatient Registration) is contrary to the intent of the step down process and does not provide a more accurate allocation of costs than would be accomplished through the step down process. This portion of the Intermediary's reclassification adjustment is affirmed.

Issue 2: Emergency room physician billing revenue

The Intermediary's adjustment reconciling the general ledger to the contractual services log for ER physicians was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

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

Date of Decision: June 27, 2001

For The Board

Irvin W. Kues
Chairman