PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D6

PROVIDER –
Saint Mary's Medical Center
Saginaw, Michigan

Provider No.: 23-0077

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING –
September 8, 2004

Cost Reporting Periods Ended -
June 30, 1994 and June 30, 1995

CASE NOs.: 97-0592 and 98-1495

INDEX

ISSUE:

For purposes of allocation of Administrative & General ("A&G") costs, should the Part B physicians' compensation and related fringe benefits be included in total expenses of private physician practices?

STATEMENT OF THE CASE AND APPLICABLE LAW:

This is a dispute over the amount of Medicare payment due to a provider of health care services.

The Medicare Program's payment and audit functions are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS.

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 what portion of those costs are 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 informs the provider in 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 NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Hospital providers sometimes employ physicians who render direct patient care in outpatient clinics owned by the hospital. In those instances, the costs of the private clinics are not reimbursed under Medicare Part A.[1] Because the hospital furnishes administrative services to the private clinics, Medicare requires that a portion of the hospital's cost be allocated to the private clinic in the cost report to avoid Medicare's subsidizing the private clinics. To accomplish this result, the private clinic expenses are accumulated in a non-reimbursable cost center on the cost report. The amount allocated is derived from statistics developed in the hospital's cost reporting process. The specific question in this case is whether the physicians' salaries and fringe benefits should be excluded from the non-reimbursable cost center prior to the allocation of hospital administrative and general (A&G) costs to the private clinic.

Background of the Dispute:

St. Mary's Medical Center ("Provider") is a non-profit, general acute care hospital located in Saginaw, Michigan. For cost reporting periods ending June 30, 1994 and June 30, 1995, the Provider operated outpatient clinics separate from the hospital. On its cost report, the Provider did establish a non-reimbursable cost center to

[1] The physicians services to Medicare patients may be reimbursed under Part B of the Medicare program, however.

accumulate the costs associated with the non-reimbursable outpatient clinics. In case number 98-1495, the Provider included in the non reimbursable cost center salaries and related employee benefits that were associated with the physicians employed in the clinics, but it also included adjustments on its cost report to remove these salaries and benefits. The intermediary's refusal to allow those adjustments had the effect of increasing the expense of the non-reimbursable cost center. In case number 97-0592, the Provider filed an amended cost report prior to the Intermediary's issuing an NPR that eliminated the cost of the physicians' salaries and benefits from the non-reimbursable cost center. The Intermediary refused to accept the amended cost report.

The Provider was represented by Leo E. Jancilla, Financial Consultant, Strategic Reimbursement, Inc. The Intermediary, United Government Services, LLC was represented by Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

JURISDICTIONAL CHALLENGE:

The Intermediary contends that the Board does not have jurisdiction of Case No. 97-0592 (cost reporting period ended June 30, 1994), in which the Intermediary refused to accept the amended cost report. The Intermediary relies on the HCFA Administrator's vacating of the PRRB's decision in Bon Secours Heartland Home Health Agency v. Blue Cross and Blue Shield Association, PRRB Dec No. 93-D49, June 23, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,754 Vac'd. HCFA Adm. Dec, Aug. 23, 1993, CCH ¶ 41,690 (Bon Secours). There, the provider made a request to refile a cost report and the intermediary denied that request. The HCFA Administrator stated that since the cost report was not filed, there was no claim for reimbursement.

The Provider responds that the Board has jurisdiction to hear the dispute in this case because the Provider refiled its cost report as evidenced by the Intermediary's Supplemental Position paper at page 3. Because the Provider filed an amended cost report, it filed a claim for reimbursement and the Bon Secours rationale does not apply.

The Board majority finds that the Provider's amended cost report submitted before the Intermediary issued an NPR is tantamount to an objection made by the Provider in its originally filed cost report. Thus, the Provider can make a claim for adjustment of the original report as long as the NPR has not been issued by the Intermediary. The Board majority, therefore, concludes that it has jurisdiction to hear the disputed claim.

PROVIDERS' CONTENTIONS:

The Provider contends that the policy of not eliminating physician compensation from the non-reimbursable cost center stems from the position written in various regional CMS letters.[2] The letters state, in part:

> Since physicians medical and surgical services rendered directly to a patient are paid under Medicare Part B, the Medicare Part A certified provider is not entitled to recover or include costs associated with this activity in its reimbursable costs. Therefore, the Fiscal Intermediary must ensure that any indirect costs incurred by the Medicare certified provider in its operation of a physician's clinic or other non-patient care related activities are captured during the Medicare Cost Report cost finding process.

The letters further state:

> In addition, HCFA noted that Fiscal Intermediaries are permitting the elimination, via Worksheet A-8-2 or directly on Worksheet A-8, of nonreimbursable clinic physicians payments included within the physician clinic cost center. These payments were made through either the certified provider's payroll or accounts payable systems. Therefore, the certified provider incurred administrative costs when making these payments. Worksheet A-8-2 is for the comparison of reimbursable physician Part A compensation to the "Reasonable Compensation Equivalency" guidelines. Worksheet A-8-2 may not be used to adjust physician payments included in nonreimbursable cost centers. Since the intent is to capture the certified provider's support costs incurred due to its operating this nonreimbursable activity, this cost must remain a part of the direct costs of the nonreimbursable activity. This is confirmed in Provider Reimbursement Manual ("PRM"), Part I §2110.4 and Part 2 §3610.

The Provider believes that the Medicare instruction at HCFA Pub. 15-1 §2328E (*Amount Applicable to Part B for Hospital Based physicians*), not the letters, governs this issue and argues that Medicare Manual instructions always take precedent over CMS/Intermediary letters. That instruction provides, in part:

> Since this amount is generally based upon the direct salary and fringe benefits of the physicians, no general service costs would normally apply and the adjustment would be made on the Adjustments to Expenses worksheet. If, however, the contractual agreement with hospital-based physicians requires the physicians to reimburse the

[2] See, Provider's Supplemental Position Paper at page 7.

> hospital for costs incurred by the hospital related to physician services, these costs should bear an appropriate portion of general service costs.

The Provider interprets this instruction to mean that unless physicians reimburse the hospital for its costs relating to the physician services, the physician fees should be eliminated from the cost report on Worksheet A-8 or Worksheet A-8-2.

At issue here is the Intermediary's reversal of the Provider's Worksheet A-8 offsets for payments to hospital-based physicians where the provider bills Medicare Part B on form CMS-1500 (direct billing). The Provider contends that Medicare regulations and cost report instructions state that the cost of physician services for direct patient care, payable from the Medicare Part B Trust Fund (Part B), are not reimbursable under Medicare Part A and should be eliminated from the Medicare cost report on either Worksheet A-8 or Worksheet A-8-2. The regulations do not distinguish between physicians who work in reimbursable and non-reimbursable cost centers. The Provider also points out that in years prior to the Prospective Payment System (PPS), when a provider compensated a physician for direct patient care services provided in a non-reimbursable off-site clinic, these costs were eliminated from the cost report. The Provider concludes from these instructions and the historical treatment that it has always been the intent of the Medicare program to remove all Part B physician compensation from the cost report.

The Provider further argues that another instruction, HCFA Pub. 15-1, Part 2 §3610, describes what is included in a non-reimbursable physician private practice cost center. The list of includable costs identifies all types of private practice costs except physician compensation. The purpose of including these types of costs in a non-reimbursable cost center is for it to receive its pro-rata share of hospital overhead. The Provider argues that the physician fees should not be listed because that would be in direct conflict with HCFA Pub.15-1 §2328, which specifically states that there may be some physician expense that may be included in hospital costs. That allowability is determined under HCFA Pub. 15-1 §2182. The cost report instruction implies that the hospital-based physician costs should be included on a reimbursable line in the cost report through a Worksheet A-6 cost reclassification. The physician costs would then be subject to the provisions of HCFA Pub. 15-1 §2182.

The Provider observes that Medicare interchanges the terms "hospital-based physician" and "provider-based physician" on a regular basis. While these physicians may not be spending time in the main hospital facility, they are working on hospital property. Since the hospital pays the compensation of the physician, whether through the payroll system or the accounts payable system, the revenue generated by the physicians is deemed hospital revenue that is recorded on its general ledger.

The Provider contends that prior Board decisions support its position. It cites Hyde Park Nursing Home (Staatsburg, NY) v. Blue Cross Association/Blue Cross and Blue Shield of Greater New York, PRRB Dec. No. 82-D114, July 2, 1982, Medicare and

Medicaid Guide (CCH) ¶ 32,095; Franklin Nursing Home (Flushing, NY) v. The Travelers Insurance Company, PRRB Dec. No. 83-D80, May 25, 1983, CCH ¶ 33,021; Concourse Nursing Home (Bronx, New York) v. Travelers Insurance Company, PRRB Decision No. 83-D152, September 27, 1983, CCH ¶ 33,596.

Additionally, the Provider contends that Medicare instructions have taken a strict position regarding allocating overhead costs to Part B physicians. HCFA Pub.15-1 §2122.3 prohibits allocating FICA and other employment related taxes directly to the hospital based physicians' professional component.

The Provider disputes the Intermediary's argument that HCFA Pub. 15-1 §2328 denies offset from non-reimbursable cost centers. It interprets this section as clearly stating that revenue derived from non-allowable activities must not be offset against the non-allowable cost centers. It asserts that the Intermediary takes out of context the wording presented in HCFA Pub. 15-1 §2328E as the basis for not allowing the offset of Part B Physician compensation and focuses on the wording that no general service costs would normally apply. The Provider alleges that the Intermediary's statement that the physician clinics, standing alone, would never represent a separate cost center is false. These departments are separately accounted for in the Provider's financial accounting system. Overhead costs are allocated to them on Worksheet B-1 of the Medicare cost report. The Provider's departments must follow the by-laws, policies and procedures of the Provider.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue is one of cost-finding which is defined in 42 C.F.R. §413.24(b). The physicians working in the group practices and their support staff are the primary component of direct costs. The goal of the cost finding process is to determine the appropriate share of indirect costs associated with the practices. The Provider uses the step-down method described in 42 C.F.R. §413.24(d)(1). It is undisputed that all costs of the physician group practices are non-allowable, that the practices are "revenue producing," and that the physician practices at issue meet the definition of a cost center.

The Intermediary contends that HCFA Pub. 15-1 §2328 covers the distribution or allocation of general service costs to non-allowable cost centers. The Intermediary argues that the first paragraph applies without exception. It acknowledges that a superficial review of the Manual's language may support the Provider because of the reference to physicians; however, it asserts that a deeper analysis rebuts this argument. The Intermediary observes that of critical note is the statement "no general service costs would normally apply." Id. That qualified observation is correct in the context of how hospitals utilize hospital-based physicians. They are engaged to provide the professional service component crucial to the delivery of an ancillary service in which hospital equipment, support staff, and premises are indispensable. Examples are the reading of x-rays, interpreting lab tests, and examining patients in the emergency room. In that context, the statement "no general service cost would

normally apply" is correct. The Intermediary argues that the difference in this case is that the physicians are an integral part of a complete business, although non-allowable, owned and operated by the cost report filing entity. General service costs definitely apply and must be allocated. The physician relationships covered in HCFA Pub. 15-1 §2328 E would never, on their own, represent cost centers. Further, if two-thirds of the cost center's expenses are removed, inadequate administrative and general costs will be allocated and resulted in cost shifting in its most basic form.

In response to the Provider's argument that HCFA Pub. 15-2 §3610 supports its position, the Intermediary again emphasizes that context is critical. The cost report section covers the situation of a hospital as a landlord. It rents space to physicians but does not employ them.

The Intermediary observes that the three cases cited by the Provider present a different factual situation than the instant case. All three of the appealing providers in those cases were skilled nursing facilities (SNFs) that employed physicians in the role of attending physicians. The providers argued and the Board rejected a cost report treatment in which the physicians would be considered interns/residents in a non-approved program. The fact pattern is not analogous to the Provider's. Moreover, a case more on point is Chestnut Hill Mental Health Center v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Dec. No. 92-D29, April 10, 1992, CCH ¶ 40,238. That provider owned and operated two psychiatric clinics. The clinics employed psychiatrists and psychologists. Establishing the clinics as non-allowable cost centers was found to be correct.

Finally, the Intermediary observes that the Provider relies on several letters or policy statements of CMS to support the treatment at issue,[3] but it responds that these documents support keeping all physician costs in the non-allowable cost centers. Contrary to the Provider's assertion, the Intermediary insists that its case is not based solely on those letters. It maintains that the analysis above supports its position without reference to the CMS interpretations. The letters' interpretation is correct because it is based on the Medicare regulations, program instructions and case precedent.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence presented and parties' contentions, finds and concludes that the Provider cannot remove physician compensation and related fringe benefits from its established non-reimbursable cost center for the purpose of overhead cost allocation. The Board observes that the Provider's arguments characterize all physicians as hospital-based, but the Board finds this premise to be incorrect. The services rendered by the physicians at the Provider were professional services for patients of the Provider. The Provider was the employer of the physicians in a group practice.

[3] See Intermediary Supplemental Position Paper at page 7.

Physicians can offer three types of professional services to providers:

(1) Physician services to the provider as described in 42 C.F.R. §405.480;
(2) Physician services to patients as described in 42 C.F.R. §405.550;
(3) Activities of a physician, such as funded research that are not reimbursable under either Part A or Part B of Medicare.

Because the Provider had only physician services related to patients and the Provider billed for physician services under Medicare Part B, the Board finds that 42 C.F.R §405.550 applies. The reimbursement received by the Provider was on a reasonable charge basis. This methodology was designed to cover physician compensation as well as other overhead costs of physicians in their offices.

Regarding whether to include physician compensation and fringe benefits in the base for allocating administrative and general costs, the Board finds that these costs should remain in the base for allocation. This allows full overhead costs to be allocated to the physician offices and the remaining residual administrative cost to be allocated to the Provider. If the physician compensation costs were removed from the allocation cost base, it would result in additional overhead costs being allocated to the Provider. It would allow double reimbursement for the Provider's administrative costs, i.e., once through the physicians' charges which include physician office overhead costs and again through the Provider's cost finding. This is obviously not the intent of the Medicare regulations.

Finally, the Board finds that the Provider's reliance on Program instructions is misplaced. The Board finds that HCFA Pub. 15-1 §2328 applies in this case, and that it is consistent with Medicare regulations. Based on the above analysis, the Board concludes that physician compensation should remain in the non-allowable cost center and should be used in the base for distributing administrative and general expenses among the cost centers on the Provider's cost reports.

DECISION AND ORDER:

Physician compensation should be: (1) included as part of a non-reimbursable physician offices cost center and (2) part of the allocation base used to distribute A&G expenses.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire

Gary Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA (Dissenting as to Jurisdiction)
Anajli Mulchandani-West

FOR THE BOARD:

DATE: November 23, 2004

Suzanne Cochran, Esquire
Chairman

Dissenting Opinion of Elaine Crews Powell

I respectfully disagree with the majority's opinion accepting jurisdiction over the physician salary and benefit cost issue in the 1994 cost report at issue in this case.

My colleagues believe that the Provider's filing of an amended cost report before the issuance of a Notice of Program Reimbursement (NPR) for 1994 is equivalent to the Provider having raised the issue on its as-filed cost report. I dissent.

I find support for my position in the plain language of the controlling regulation at 42 C.F.R. 413.24(f), which states in relevant part:

> Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by CMS.

Clearly, the acceptance of an amended cost report is a discretionary act over which CMS or its fiscal intermediary delegate has control. Nowhere in the regulations do I find support for the proposition that a provider may, at its discretion, substitute an amended cost report for its initial filing. Nor do I find support for the proposition that appeal rights emanate from an amended cost report that an intermediary did not accept.

I am in complete agreement with the provisions of §2931.2A of the Provider Reimbursement Manual where it states in relevant part:

> Once a cost report is filed, the provider is bound by its elections. . . . a provider may not file an amended cost report to avail itself of an option it did not originally elect.

The Provider included physician salary and fringe benefit costs associated with private physician offices in a non-reimbursable cost center on its as-filed cost report. It then proposed the elimination of these costs from the non-reimbursable cost center via an amended cost report. In accordance with its authority, the Intermediary did not accept the amended report. I find that this inaction on the part of the Intermediary did not constitute a "final determination" with respect to these costs. The Intermediary issued an NPR for the FYE 06/30/94 without making an adjustment to the physician compensation costs; therefore, the Provider fails to meet the dissatisfaction requirement of Section 1878(a) of the Act.

Regarding the merits of this case, I am in full agreement with my colleagues.

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Elaine Crews Powell