# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D36

**PROVIDER** -
University Medical Center
Tucson, Arizona

Provider No.: 03-0064

**vs.**

**INTERMEDIARY** -
BlueCross BlueShield Association/
Blue Cross & Blue Shield of Arizona

**DATE OF HEARING** -
January 15, 2004

Cost Reporting Periods Ended -
June 30, 1998 and June 30, 1999

**CASE NOS.:** 02-0216 and 02-0217

**INDEX**

ISSUE:

1. Were the Intermediary's adjustments reducing the Provider's Indirect Medical Education (IME) full-time equivalent (FTE) resident count for time spent by residents in research proper?

2. Were the Intermediary's adjustments reducing the Provider's FTE resident count for IME and Direct Graduate Medical Education (GME) for time spent by residents on vacation proper?

STATEMENT OF THE CASE AND 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 to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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 the proportion of those costs 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 issues the provider 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system Medicare's payment for inpatient Part A operating costs is made on a per discharge basis; Medicare discharges are classified into diagnostic related groups (DRG) and a specific payment rate is assigned to each DRG with respect to resource use or intensity. Part A inpatient costs include general routine service costs, ancillary service costs, and intensive care-type service costs, but exclude certain other costs such GME expenses and kidney acquisition costs. In addition, an add-on payment or adjustment is made under PPS for the indirect costs of medical education.

In general, a PPS hospital's GME costs are determined by multiplying its "average per resident amount," a hospital specific rate that had been determined from a base period (42 U.S.C. §1395ww(h)(2)), times the number of FTE residents that worked at the facility. 42 U.S.C. §1395ww(h)(4). These costs are then apportioned to Medicare based upon a hospital's ratio of Medicare inpatient days to total inpatient days. Implementing regulations at 42 C.F.R. §413.86(f) provide specific rules for counting FTE residents for GME.

Authority for the payment of IME expenses is found at 42 U.S.C. §1395ww(d)(5)(B). In general, the statute explains that a hospital's adjustment for IME is calculated by multiplying its total DRG revenue by its ratio of FTE residents to its number of beds. Implementing regulations at 42 C.F.R. §412.105(f) provide the rules for counting FTE residents for this purpose.

University Medical Center (Provider) is a non-profit acute care teaching hospital located in Tucson, Arizona. As a teaching facility reimbursed under PPS, the Provider appropriately claimed reimbursement for the direct and indirect costs of its graduate medical education training programs. Blue Cross and Blue Shield of Arizona (Intermediary) reviewed the Provider's cost reports for its fiscal years ended (FYE) June 30, 1998 and June 30, 1999, and made adjustments affecting the Provider's IME and GME payments. Specifically, the Intermediary reduced the Provider's FTE count for time spent by residents in research and other scholarly activities and for time spent by residents who took vacation while on rotation to other hospitals.[1] With respect to time spent in research activities, the Intermediary reduced the Provider's resident count for IME by 10.06 FTEs in 1998 and by 4.96 FTEs in 1999.[2] With respect to time spent on vacation, the Intermediary reduced the Provider's resident count for IME by .02 FTEs in 1998 and by 4.87 FTEs in 1999, and by a similar number of FTEs for GME in these periods.[3]

The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835- 405.1841 and met the jurisdictional requirements of those regulations. The amount of program funds in controversy is approximately $766,498, calculated as follows:

FYE 1998[4]

| | |
|---|---|
| IME Research Issue | $285,751 |
| IME Vacation | 26,263 |
| GME Vacation | 4,152 |

[1] Initially the Provider's argument regarding vacation time included time spent by residents on leave of absence. However, the parties have subsequently resolved the leave of absence matter and it is no longer at issue in these cases. See Intermediary's letter dated August 3, 2004.

[2] Provider's Post-Hearing Brief at 6.

[3] Provider's Post-Hearing Brief at 27.

[4] Provider's Supplemental Position Papers at 2. Intermediary's Revised Final Position Papers at 2.

| | | |
|---|---|---|
| | | $316,166 |
| FYE 1999 | | |
| IME Research Issue | $142,875 | |
| IME Vacation | 255,361 | |
| GME Vacation | 52,096 | |
| | | $450,332 |
| TOTAL | | $766,498 |

The Provider was represented by Gregory Etzel, Esq., of Vinson & Elkins, L.L.P. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and evidence presented, finds as follows:

Issue No. 1-Research Time

The Intermediary contends that time spent by residents performing research activities that is not directly related to the care of patients is excluded from the resident count. In the instant case, only resident rotations specifically titled "research" were excluded from the Provider's IME count, and the Provider submitted no documentation to show that the time was, in fact, patient-care related. The Intermediary cites section 2405.3.F.2 of the Provider Reimbursement Manual, which states that a resident must not be included in the IME count if "[t]he individual is engaged exclusively in research," and 66 Federal Register No. 148, 39896, August 1, 2001, where CMS explains that "exclusively" means that the research is not associated with the treatment or diagnosis of a patient. The Intermediary also cites 42 C.F.R. §412.105(f)(1)(iii)(B), amended through the August 1, 2001, Federal Register, which CMS notes as a clarification of long-standing policy. The section states "[t]he time spent by a resident in research that is not associated with the treatment or diagnosis of a particular patient is not countable."

The Provider contends that the time residents spend performing research activities as part of an approved residency program is included in the IME calculation based upon the pertinent statute and controlling regulation. While 42 U.S.C. §1395ww(d)(5)(B) provides specific instructions for calculating the IME adjustment, it does not disallow time spent by residents performing research activities regardless of whether it is related to patient care. Regulations at 42 C.F.R. §412.105(f) provide more specific rules for counting FTE residents for IME. These rules require only that residents who worked in nonhospital settings be engaged in patient care activities in order to be included in the IME count. The Provider also contends that the August 1, 2001 amendment to the IME regulation cannot be viewed as a clarification of existing policy since it establishes new recordkeeping requirements; i.e., time spent by residents performing patient and non-patient care activities while assigned to a research rotation. Accordingly, this

amendment cannot be applied to the subject cost reporting periods since retroactive rule making is prohibited.

The Board finds that the regulation in effect during the subject cost reporting periods does not exclude research time from the IME resident count nor does it require resident time to be related to patient care. As noted above, 42 C.F.R. §412.105(f) provides the rules for counting FTE residents for IME. In part, the regulation states:

> (1) . . . the count of full-time equivalent residents for the purpose of determining the indirect medical education adjustment is determined as follows:
>
> (i) The resident must be enrolled in an approved teaching program.
>
> (ii) In order to be counted, the resident must be assigned to One of the following areas:
>
> (A) The portion of the hospital subject to the prospective payment system.
>
> (B) The outpatient department of the hospital.
>
> (C) Effective for discharges occurring on or after October 1, 1997, the time spent by a resident in a nonhospital setting. . . .

Since it is undisputed that the residents at issue in this case were enrolled in an approved GME program and that they worked in either the portion of the Provider's facility subject to PPS or an outpatient area, the Intermediary's adjustments were improper. The Board notes that this finding is consistent with the court's findings in Riverside Methodist Hospital v. Thompson, No. C2-02-94 (S.D. Ohio, July 31, 2003) (Riverside). In part, the court concluded that "the [IME] regulation as it was written at the time in question, does not by its plain language contain any requirement that the time spent by residents had to be spent in direct patient care in order to be counted."[5]

Moreover, the Board finds that the 2001 amendment to the IME rule excluding non-patient care research time from the resident count represents a change in policy that cannot be applied retroactively to the subject 1998 and 1999 cost reporting periods. As the court in Riverside explained, the IME regulation is clear, in that the time spent by residents performing non-patient care related activities is not excluded from the resident count, and "if the Secretary desires to include a new requirement regarding excludable time, it must be done by amendment, and in compliance with the necessary administrative procedures for amending regulations. . . ."[6]

---

[5] See Riverside, pg. 15.

[6] Id.

Issue No. 2-Vacation Time

There is no dispute that the time spent by residents on vacation is included in the FTE resident counts for both IME and GME; rather, the issue in this case is which hospital is entitled to claim the vacation time for purposes of program reimbursement. The Provider believes the most accurate method is to include vacation time in the resident count for the hospital that pays the residents' salaries even if they are on rotation to another hospital when the vacation time is taken. The Intermediary believes it is common practice to include vacation time in the resident count for the hospital where residents are assigned and working when vacation time is taken. The Intermediary asserts that this method of counting vacation time helps assure that no resident is counted as more than one FTE.

The Board finds that both the IME and GME regulations are silent with respect to vacation time. However, both rules require hospitals to report the dates each resident is assigned to their facility and the dates each resident is assigned to other hospitals. The Board concludes, therefore, that basing resident counts on rotation assignments without a specific accounting for vacation time on a hospital by hospital basis, as was done by the Intermediary, is proper. The Board notes that the critical factor is consistency. As long as vacation time is accounted for in the same manner for each hospital, as presented by the Intermediary, each hospital will be properly reimbursed.

DECISION AND ORDER:

Issue No. 1-Research Time

The Intermediary's adjustments excluding research time from the FTE resident count used to calculate the Provider's adjustment for IME were improper. The Intermediary's adjustments are reversed.

Issue No. 2-Vacation Time

The Intermediary's adjustments excluding vacation time from the FTE resident counts used to calculate the Provider's adjustment for IME and the Provider's GME costs were proper. The Intermediary's adjustments are affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West

FOR THE BOARD:

DATE: April 12, 2005

Suzanne Cochran, Esq.
Chairman