PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D3

PROVIDER -
Trenton Psychiatric Hospital
Trenton, New Jersey

Provider No.: 31-4013

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Riverbend Government Benefits
Administrator

DATE OF HEARING -
August 17, 2005

Cost Reporting Periods Ended -
June 30, 1997; June 30, 1998; June 30, 1999
and June 30, 1996

CASE NOs.: 02-1765; 02-1766; 02-1767 and
03-0825

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ISSUE:

Whether the Intermediary's adjustments to disallow reimbursement for physicians' professional services on a reasonable cost basis was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement to a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payment for those services. The Centers for Medicare and 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's determination 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.

Pursuant to the provisions of 42 C.F.R §405.521, for periods prior to July 1, 1996 and 42 C.F.R §415.160, effective July 1, 1996 and forward, payment for physician services furnished to Medicare beneficiaries in a teaching setting are covered under Medicare Part B except in those hospitals that have elected cost reimbursement. A hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on a reasonable charge or fee schedule basis that might otherwise be payable for those services if the hospital has an approved teaching program and meets the specific conditions of 42 C.F.R §405.521(d)(3) or 42 C.F.R §415.160(b).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Trenton Psychiatric Hospital (Provider) is an inpatient teaching psychiatric hospital located in Trenton, New Jersey. The Provider requested payment for physician professional services on a reasonable cost basis on its fiscal year 1996, 1997, 1998 and 1999 cost reports. Upon final settlement of the cost reports, Riverbend Government Benefits Administrator (Intermediary) disallowed the reasonable cost payments for physician services. The estimated Medicare

reimbursement effect for the four years at issue is $1,101,823, $1,147,301, $1,068,365 and $1,196,132, respectively.

The Provider appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835- 405.1841. The Provider was represented by Peter C. Harvey, Attorney General of New Jersey. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

By letter dated December 19, 1991, the Provider submitted written notification informing the Intermediary that, effective January 1, 1992 the Provider would continue to bill for physician professional services on a per diem, or cost basis[1]. Per the December 19, 1991 letter, the Provider was requesting validation of its billing practices, including the billing of physician services to Medicare beneficiaries on a cost basis, due to legislative changes which may have impacted how it was to bill the Medicare program. The Intermediary then issued a written response on June 3, 1993, informing the Provider that its request to continue to bill the Intermediary for the physician services had been denied, and that the Provider was to bill the carrier to be reimbursed for those services from the Part B trust fund. [2] The Intermediary did not state its rationale for the denial. The Provider did then bill Part B as instructed.

The Provider asserts that it met the conditions set forth in 42 C.F.R. §405.521 and §415.160 [3] to bill for physician professional services on a reasonable cost basis rather than on a fee for service basis. Those conditions require that the Provider be a teaching facility; that the Provider request the election of payment of physician professional services on a reasonable cost basis;[4] and that all physicians who furnish Medicare covered services agree not to bill the charges or, if they are employees of the provider, are precluded from billing for services as a condition of their employment.

The parties are in agreement that the Provider is a certified teaching hospital and therefore meets the first condition to bill on a reasonable cost basis.

The Provider asserts[5] that the physicians who provided professional services to Medicare beneficiaries in the hospital did not bill for those services and it submitted copies of signed physician agreements authorizing the Provider to bill and retain payment for all physician services rendered. The Intermediary did not dispute that the Provider's physicians agreed not to bill for physician services rendered to beneficiaries, so it is therefore uncontested that the Provider met the physician billing condition to elect reasonable cost reimbursement.

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[1] See 03-0825 Provider Position Paper, Exhibit P-10.
[2] See 03-0825 Provider Position Paper, Exhibit P-12.
[3] For FYE 1996, 42 C.F.R 405.521 is applicable. 42 C.F.R 415.160 became effective July 1, 1996 and would apply to FYE's 1997, 1998 and 1999.
[4] 42 C.F.R 415.160(b)(1) requires a "written" election be made. 42 C.F.R 405.521(d) does not specify that a "written" election be made.
[5] See Page 2, Statement of Facts, in each year of the Provider's position paper.

The Provider asserts that a written election to be reimbursed for physician services on a reasonable cost basis was made for cost reporting years 1996-1999 in that both the December 19, 2001 and the May 12, 1993 letters to the Intermediary represent an election to bill for physician services on a reasonable cost basis. In addition, the Provider contends that the cost report submissions, which included claims for physician services on a reasonable cost basis, represent elections to have those services reimbursed on cost, rather than the fee schedule.

The Provider asserts that the Intermediary's denial of reimbursement of physician services on a cost basis was unfounded, as the regulation does not include language indicating that the Intermediary will accept or deny the election, only that an election be made. The Provider contends that as long as the election is made and the conditions set forth in the regulation are met, the Intermediary did not have the authority to deny the request. The Provider asserts that in each letter to the Intermediary the regulatory requirements of obtaining cost reimbursement for those services were addressed, and the Intermediary's denial response was erroneous and did not communicate how the regulatory requirements had not been met.

The Intermediary contends in its position paper that the 1991 letter from the Provider did not serve as an election. In a letter dated November 15, 2001 the Intermediary also asserts that it never responded to the Provider's 1991 and 1993 requests to bill on the cost basis with an approval.[6] The Intermediary also contends that if the Provider believed that it had made an election to receive cost reimbursement for physician services, the Provider should not have billed and obtained reimbursement for those services from the Part B Carrier.

The Intermediary maintains that because the Provider was reimbursed as a teaching hospital based on a per-resident FTE amount for its physician teaching services and by the Part B Carrier for its professional services, the Provider is requesting duplicate payment for services by claiming the cost of professional services on the cost report. The Intermediary claims that it received guidance from both CMS in 1993 and the Blue Cross and Blue Shield Association in 2001 to deny the cost based payments.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

While it is unclear as to how the Provider billed for physician services prior to FYE 1996, it is undisputed that the Provider met the conditions set forth in the regulations to make an election to bill for physician services on a reasonable cost basis for the years in question. Whether the Provider made such an election for the relevant cost reporting periods is the issue. Based on a review of the regulations in effect for FYs 1996-1999, it does not appear that the Provider had to make an annual election or, that once an election was made, that the Intermediary had to approve such an election. The regulations state only that an election has to be made and do not speak to a necessary approval from the Intermediary. The Board finds that the December 19, 1991 and the May 12, 1993 letters to the Intermediary, in conjunction with the as-filed cost-reports claiming

[6] See 03-0825 Provider Position Paper- Exhibit 13.

cost-based reimbursement for physician services, do qualify as an election to be reimbursed on a reasonable cost basis for each of the FYs in question.

The authors of the June 3, 1993 and November 15, 2001 letters from the Intermediary ignore the reasonable cost options offered in the regulations even though the Provider references the specific regulations in each request or election letter. The Intermediary's first denial letter of June 3, 2001 mentions only that the Provider should be reimbursed by the Part B Carrier for Part B services and that teaching physicians are reimbursed through the GME FTE per-resident amount for their Part A teaching time; it ignores the fact that the regulations allow for an alternate reimbursement methodology.

In addition, the Intermediary's reasoning for denying the election in its November 15, 2001 letter[7], based on the Provider's "waiving" of the election due to the Provider billing Part B for physician services, is unfounded. The Board finds that the Provider acted reasonably in following the Intermediary's instructions to bill the charges to Part B, because if the cost report claim for cost reimbursement of those services was denied, the Provider may have lost the ability to bill the carrier for the services rendered. The result would have been that the Provider would have received no reimbursement, as the Intermediary would have disallowed cost reimbursement.

The Board also finds that the Provider Reimbursement Manual, PRM 15-1 §2148.5, contemplates the situation where Part B charges are billed to the carrier but are reimbursable on the Part A Medicare cost report. This manual provision instructs the Intermediary to reduce the computed cost payment by aggregate reasonable charges applicable to any services reimbursement by the Part B Carrier for the period in question. Therefore, the Provider billing Part B charges to the Carrier does not duplicate billings and is not a reason to deny cost reimbursement.

Finally, the Board concludes that 405.521(d)(3) instructs the Intermediary on how to handle the computation of the GME per-resident amount in situations where the Provider elects cost reimbursement for physician services. Therefore, the Provider being reimbursed a per-resident amount for GME should not preclude the Provider from electing cost reimbursement for physician services and being paid in that manner.

DECISION AND ORDER:

The Provider is entitled to be compensated on a reasonable cost basis for its physician services, net of Part B Carrier billings. The Intermediary's adjustments are reversed and the case is remanded to the Intermediary for the calculation of reimbursement on a reasonable cost basis, pursuant to the regulations in effect for each cost reporting year.

[7] The October 11, 2001 letter to the Intermediary from the Provider, in which this letter is a response to, was not included in the record.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: November 17, 2005

Suzanne Cochran
Chairperson