PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D30

PROVIDER -
Via Christi Regional Medical Center
Wichita, Kansas

Provider No.: 17-0122

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
BlueCross BlueShield of Kansas (n/k/a
Wheatlands Administrative Services)

DATE OF HEARING -
January 19, 2005

Cost Reporting Period Ended -
September 30, 1996

CASE NO.: 99-2858

INDEX

ISSUE:

Whether the Intermediary's computation of the IME and DGME count as it relates to the following components was correct.

a) Family practice rotations to the continuity care clinic;
b) Internal medicine rotations to the St. Joseph campus of the Provider; and
c) Exclusion of psychiatric rotations in clinical research activities from IME FTE Count.

MEDICARE 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 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 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. §1395h, 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.

Medicare reimburses teaching hospitals for their share of costs associated with direct graduate medical education (DGME) and indirect medical education (IME). The calculation of reimbursement requires a determination of the total number of full-time equivalent (FTEs) residents in the teaching program. This case arises from a dispute over the FTE count.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Via Christi Regional Medical Center (Provider) operates two campuses, the St. Joseph Campus and the St. Francis Campus, under the same Medicare provider agreement and provider identification number. Blue Cross and Blue Shield of Kansas (Intermediary)

audited the Provider's fiscal year ended (FYE) September 30, 1996 cost report and made adjustments to the disproportionate share hospital (DSH) adjustment, non-reimbursable affiliated hospital costs and DGME and IME FTE count.

The Provider timely appealed these adjustments to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-1841 and has met the jurisdictional requirements of those regulations. The Intermediary and Provider have agreed to administratively resolve the DSH and affiliated hospital issues upon the outcome of the appeal concerning IME and DGME.[1] The amount of Medicare reimbursement related to the DGME and IME issue for FYE 1996 is approximately $600,000.[2]

The Provider was represented by Kenneth R. Marcus, Esquire, of Honigman Miller Schwartz and Cohn, LLP. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

In order to verify the FTE count, the Intermediary requested a list of interns and residents in approved programs working at the hospital during the cost reporting period. During this time period, the Provider did not maintain actual time records for its interns and residents. In lieu of actual time records, the Intermediary accepted rotation schedules as documentation to support the FTE count.

The Provider challenges the Intermediary's determination regarding the appropriate intern and resident FTE count for purposes of computing the Medicare DGME and IME adjustments for FYE 9/30/96, which was the Provider's base year for establishing the caps on FTE interns and residents in future years. The Provider is appealing the DGME/IME FTE counts for the following issues:

a) Family practice rotations at the continuity care clinic

As required by the Accreditation Council for Graduate Medical Education (ACGME), family practice interns and residents are assigned a panel of patients to whom they furnish care during the 36 months that they are enrolled in a family practice residency program. This setting is commonly known as "continuity care clinic," in which each trainee is required to provide services to its panel of patients at an assigned time, which varies according to post graduate year (PGY) status.

In FYE 9/30/96, the Provider's family practice interns and residents from the St. Joseph's and St. Francis campuses were assigned to a continuity care clinic, located on the respective campuses of each hospital. During FYE 9/30/ 96, Medicare regulations did not permit the Provider to include in the IME FTE count time spent in rotations to non-provider settings. The Intermediary requested additional information from the Provider to clarify the nature and setting (or location) of the rotations reported on the Provider's

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[1] See Stipulation, Provider Post-hearing Brief, Exhibit 2. The Board affirms the agreement of the parties as to the facts and proposed adjustments relating to these issues as set forth in the stipulation.

[2] Since FYE 1996 is the Provider's base year for establishing the cap on FTE interns and residents, it has an impact on subsequent fiscal years.

resident rotation schedules. The Intermediary used the Provider's rotation schedules coupled with the additional information furnished by the Provider to exclude time spent in rotations to non-provider sites.

The Provider does not challenge the removal of non-provider time from the IME calculation. The Provider, however, notes that family practice residents are required to return to the continuity care clinics to fulfill their patient care duties, even though the rotation schedules did not explicitly indicate so. The Provider further notes that contemporaneous clinic schedules provided document that family practice residents were scheduled for continuity care clinic during their rotations to non-provider sites.

b) Internal medicine rotations to the St. Joseph campus of the Provider

The Provider has two campuses with internal medicine programs. The program at the St. Francis campus is an approved graduate education program and the one at the St. Joseph campus is not. The Medicare regulations at 42 C.F.R. §413.86(f)(1)(i) count all residents in approved programs working in all areas of the hospital complex. The Intermediary did not permit any time spent by residents in the internal medicine rotation at the St. Joseph campus because the program was not an approved GME program.

c) Exclusion of psychiatric rotations in clinical research activities from IME FTE Count

The Intermediary included time spent by two of its psychiatry residents in clinical research activities, as a part of their approved program, in the Provider's DGME FTE count, but not in its IME FTE count. The Intermediary disallowed this time because it believes that the research did not involve direct patient care and the Provider could not furnish documentation as to where these activities took place.

In addition, the Provider sought to add a 3-month rotation (April-June) to the FTE count for Dr. Mark Catterson's participation in a "Com. Psych" rotation. The Intermediary did not allow this time due to lack of documentation.

PARTIES' CONTENTIONS:

a) Family practice rotations to the continuity of care clinic

The Provider asserts that there is no dispute that its family practice residents are required to provide services at its continuity of care clinic during periods when residents are assigned primarily to a "nonprovider" setting. The Provider presented evidence of this requirement in the form of an affidavit from Dr. Peggy Gardner, the Provider's Director of Medical Education. Provider Supplemental Position Paper, Exhibit P-16. The Provider also notes that the Intermediary did not question that residents were required to spend time in the continuity of care clinic but claimed that the amount of time spent at the clinic is not documented in the rotation schedule. Tr. at 44-45. Thus, the only issue is whether the Provider has presented adequate documentation to support the FTE count for time spent at the continuity care clinic.

The Provider asserts that it provided the Intermediary with adequate documentation at the time of the audit. See Provider's March 25, 1998 letter, Provider Supplemental Position Paper, Exhibit P-7. Specifically, the Provider claims that it furnished detailed schedules of the time spent by residents at the continuity of care clinic(s). It is from these schedules that the Provider has estimated the time that should be added to its FTE count.

The Intermediary asserts that it usually relies on actual time records to support the claimed FTEs and that, as early as February 12, 1995,[3] it has provided written guidance to the Provider instructing it to maintain documentation to support the actual time spent by interns and residents for the purpose of computing the IME adjustment. However, since the Provider did not maintain actual time records, the Intermediary agreed to use rotation schedules, although the rotation schedules only depicted the assignment of blocks of time but did not include any detail beyond the general rotational assignment. The Intermediary reviewed and confirmed the schedules and relied upon them to calculate the final FTE count. The Provider now claims that the rotation schedule does not reflect that every resident in the family practice residency program had a responsibility to attend the continuity of care clinic as described in the curriculum for the program. While not disputing that residents had this requirement, the Intermediary notes that this time is not reflected in the rotation schedule the parties agreed to use as documentation to support the FTE count. The Intermediary observes that if this type of error exists in the rotation schedules, there may be other errors that could reduce the FTE count. Specifically, the Intermediary notes that the continuity of care concept, as described in the GME directory, Exhibit I-4, provides that residents are to maintain patient contacts not only in clinics but also in the patient's home, extended care facilities and other remote sites. While contact with patients at the clinic would count toward the FTE count, time at these other non-Provider sites would not. The Intermediary asserts that the Provider must rely on the rotation schedule as is or develop detailed time records for all time spent by all residents.

b) Internal medicine rotation to the St. Joseph campus at the Provider

The Provider asserts there are two reasons to include internal medicine interns and residents time spent at the St. Joseph campus in the FTE count. First, both the St. Francis and the St. Joseph campuses are part of the same provider. The regulations at 42 C.F.R. §413.86(f)(1)(i) state that "[r]esidents in an approved program working in all areas of the hospital complex may be counted." Since the St. Joseph and St. Francis campuses are part of the same provider, the Intermediary erroneously concludes that St. Joseph should be treated as a distinct entity for purposes of counting FTEs. Second, all of the interns and residents were part of a fully accredited, approved internal medicine residency program operated by the University of Kansas School of Medicine (Wichita). The lack of a separate accreditation for the St. Joseph campus is not a basis to exclude the time spent there for interns and residents enrolled in other approved GME programs. The time spent at the St. Joseph campus counted toward their specialty certification, was in approved program activities, and counted toward eligibility for board certification. The

[3] See Intermediary's Final Position Paper. Exhibit I-1 letter dated 2/12/1995 from fiscal Intermediary to Provider (F.F. Christensen, Controller).

Provider presented a letter dated January 5, 2000, Exhibit P-10, in which CMS indicates that it is permissible for a hospital to count residents that are enrolled in a GME program that is not specifically approved through that hospital. The Provider also claims that the language in the preamble to CMS' PPS regulation at 70 Fed. Reg. 47452 (August 12, 2005) supports its position in that CMS allows a hospital to claim payment for training of residents so long as the residents are enrolled in an approved program and, the program need not be an approved program conducted by the Provider. See Provider's Request to File Supplemental Authority, letter dated October 25, 2005.

The Provider claims that internal medicine interns and residents, just like family practice residents, were required to return to the Provider from their non-provider rotations to fulfill on-site patient care duties, and that this time should be credited for IME. The Provider states that it provided call schedules indicating the on-call responsibility and information regarding the training sessions. The Provider estimated the time that should be added to its FTE count by counting each call rotation as a half day.

The Intermediary did not count the time spent by trainees rotating through the internal medicine program at the St. Joseph campus because this program was not approved by the ACGME. The Intermediary contends that the ACGME only approved the Internal Medicine program for the St. Francis campus. See Exhibit I-14. Even though St. Joseph Medical Center and St. Francis Regional Medical Center merged in October of 1995 to form Via Christi Regional Medical Center, the ACGME approval letter dated August 18, 1997 only listed the St. Francis campus as approved. The Intermediary notes that the regulation at 42 C.F.R. §413.86(f)(1)(i) allows residents in an approved program working in all areas of the hospital complex to be included in the FTE count. However, the Intermediary contends that the residents in the St. Joseph's internal medicine program were not in an approved program, so their FTEs can not be counted for Medicare DGME or IME reimbursement purposes.

With respect to on-site patient care duties, the Intermediary notes that the Provider did not claim this time on its cost report and only recently presented contemporaneous call schedules as evidence to estimate portions of FTEs to add back to the IME FTE count. The Intermediary's position is similar to that expressed for the family practice residents. The rotation schedules were relied upon as evidence of location for resident monthly rotations in lieu of detailed time records. The Intermediary contends that the Provider should not be allowed to add back time to the rotation schedule based on estimates and other documentation that is general in nature and not supported by specific resident time records. The Intermediary asserts that it is just as likely that incidental time spent in off-site location may have been inadvertently included in the FTE count, while the residents were, according to the rotation schedule, in on-site locations. Without precise time records, the rotation schedules should not be modified.

c) Exclusion of psychiatric rotations for clinical research activities from IME FTE Count

The Provider notes that the Intermediary included time spent by two psychiatry residents in rotations for clinical research in the FTE count for DGME, but not for IME. The basis for this exclusion was that these residents were not engaged in patient care activity. The

Provider presented evidence in the form of a letter from its Director of Medical Education attesting to the fact that these residents were engaged in patient care. Exhibit P-8. The Provider also argues that the regulation does not require residents to be engaged in direct patient care. The Provider cites the decision in Riverside Methodist Hospital v. Thompson, Case No. C2-02-94, July 31, 2003, Medicare & Medicaid Guide (CCH) ¶301,341, Exhibit P-14, in which the district court rejected the Secretary's argument that a resident is required to be engaged in patient care activity.

The Provider also seeks to include additional time for Dr. Mark Catterson in the determination of its IME and DGME count. The Provider notes that during a 3-month period (April-June), Dr. Catterson performed a "Com.Psych" rotation wherein 50 percent of his time was spent at a freestanding site, but the other 50 percent was spent in the PPS unit of the Provider.

The Intermediary questions the value of the Provider's letter supporting the claim of direct patient care. See Exhibit I-8. The Intermediary indicates that it does not represent a contemporary record that is subject to audit and does not indicate where research was conducted – inpatient, outpatient or off-site. The Intermediary asserts that sufficient documentation has not been provided.

The Intermediary notes that initially the Provider did not include the rotation time for the three months in question for Dr. Catterson in its IME and DGME FTE counts because it was in a non-provider setting, but now claims that the resident participated in a "Com. Psych" rotation in which 50 percent of his time was spent in the PPS unit. The Intermediary disallowed this time because it did not meet the requirements of 42 C.F.R. §413.86(f)(iii) which allows time spent in a non-provider setting if two conditions are met – (1) the resident spends his or her time in patient care activities and, (2) there is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital is to be paid by the hospital. The Intermediary asserts that sufficient documentation has not been provided to demonstrate that these conditions were met.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

a) Family practice rotations to the continuity of care clinic

The Board observes that in a prior year and the year at issue, the Intermediary requested that the Provider maintain actual time records for IME verification. Exhibit I-1 at 1, Comment 3. In lieu of specific records, the Intermediary used the Provider's rotation schedules despite their limitations. The Board notes that the Provider is now presenting additional documentation that indicates that while in their non-provider rotations, family practice residents were required to routinely return to the Provider to participate in the continuity of care clinic and requests that this time be added to the FTE count. The

Intermediary acknowledges this requirement was part of the family practice program but points out that these same program requirements indicate that continuity of care may be delivered at non-provider sites and that this time would not count toward the FTE count. The Intermediary contends that the Provider can not present more detailed documentation to support additions to the FTE count without presenting detailed documentation for all of the residents' time. Since the Provider does not have the time records necessary to document where residents were spending all of their time, the Intermediary claims that it must rely solely on the rotation schedules.

The Board acknowledges the Provider's assertion that the family practice residents had to return from non-provider sites for continuity of care clinics and that the documentation of clinic schedules supports this assertion. Exhibit P-8. The Provider documented that family practice residents had a program requirement to return to serve in the continuity of care clinics. Exhibit P-6. This was true even when the residents were in non-provider settings. The Provider presented documentation of the residents clinic assignments and its estimate of how much time was spent at the clinic that should be included in the FTE count for IME purposes. Exhibit P-8. The Board, however, agrees with the Intermediary that it is just as likely that some of the family practice residents' time was spent in offsite locations, and that this time was not specifically tracked by the residents or documented by the Provider. For example, the Board notes that the program requirement for residency education in family practice indicates that the continuity of care requirement may be met at non-provider sites such as patients' homes, nursing homes and extended care facilities. Exhibit P-6 at 60. Such time would have been excluded had it been properly identified in time records. The Provider does not have detailed documentation in the form of time records that would confirm, without assumptions, the precise locations and time spent by residents during their monthly rotations. The Board finds that without complete detailed time records, the Intermediary's use of rotation schedules for the FTE count was proper.

b) Internal medicine rotations to the St. Joseph campus of the Provider

The regulations at 42 C.F.R. §413.86(f)(1)(i) provides that

> [r]esidents in an approved program working in all areas of the hospital complex may be counted.

The regulation at 42 C.F.R. §413.86(b) defines what an approved medical residency program means as program that meets on of the following criteria:

> (1) Is approved by one of the national organizations listed in §405.522(a)[4] of this chapter.

[4] The regulation at 42 C.F.R. §405.522(a) reads as follows:

> Approved teaching programs. Title XVIII of the Act recognizes residency programs in providers that are duly approved in their respective fields.

(2) May count towards certification of the participant in a specialty of subspecialty listed in the current edition of either of the following publications:

(i) The Directory of Graduate Medical Education Programs published by the American Medical Association,…; or
(ii) The Annual Report and Reference Handbook published by the American Bard of Medical Specialties,…

(3) Is approved by the Accreditation Council for graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

The Board finds that the language of the regulation clearly states that if a resident is participating in an approved program than all their time spent working in all areas of the hospital complex, may be counted. The Board agrees that the regulation does not require that the approved program be operated by the hospital complex through which the residents rotate.

Besides the language of the regulation, this position is supported in the two CMS policy statements cited by the Provider. The Provider presented a letter dated January 5, 2000, Exhibit P-10, in which CMS indicates that it is permissible for a hospital to count residents that are enrolled in a GME program that is not specifically approved through the hospital. In that case, a hospital sought to count time for dental residents who were enrolled in a GME program through a school of dentistry. Id. The Provider also presented the following language from a preamble to a recent regulation, concerning the counting of residents for GME and IME:

> For example, Hospital A had no allopathic or osteopathic residents in its most recent cost reporting period ending on or before December 31, 1996. As such, Hospital A's cap for direct GME and IME are both zero. Hospital A and Hospital B enter into a Medicare GME affiliation for the academic year beginning on July 1, 2003, and ending on June 30, 2004. On July 1, 2003, Hospital A begins training residents from an existing family medicine program located at Hospital B. This rotation will result in 5 FTE residents training at Hospital A. Through the affiliation agreement, Hospital A receives a positive adjustment of 5 FTE's for both its direct GME and IME caps.

- by the Accreditation Council for Graduate Medical Education of the American Medical Association,
- by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association
- by the Council of Dental Education of the American Dental Association, or
- by the Council of Podiatric Medicine Education of the American Podiatric Medical Association (for provider cost reporting periods beginning after December 31, 1972).

70 Fed. Reg. at 47452 (August 12, 2005).[5]

While this example is presented to explain how adjustments are made under the GME cap, it is nevertheless instructive in that it indicates that to claim payment for the FTEs rotating to Hospital A from Hospital B, where Hospital B is the operator of the family practice program, a hospital may claim payment for training residents so long as the residents are enrolled in an approved program, which need not be an approved program conducted by the provider.

The Provider maintains that all of the residents rotating through the St. Joseph campus are part of the approved residency program in internal medicine operated by the University of Kansas School of Medicine at Wichita, which employs the residents. This is supported by the Graduate Medical Education Directory 1997-1998, Exhibit I-18, which shows the University of Kansas School of Medicine (Wichita) as the only sponsoring institution for internal medicine in Wichita.[6] Even though the St. Joseph campus is not listed as a major participating institution, it is not relevant, because the residents are part of an approved program. The Board finds that the Intermediary's adjustment removing time spent in the St. Joseph's internal medicine rotation was improper.

The Provider is now presenting additional documentation that indicates that while in their non-provider rotations, internal medicine residents were required to routinely return to the Provider to participate in on-site patient care duties and therefore, requests that this time be added to the FTE count. The Intermediary contends that the Provider can not support additions to the FTE count without also presenting detailed documentation for all of the residents' time. Since the Provider does not have the time records necessary to document where residents were spending all of their time, the Intermediary claims that they must rely on the rotation schedules.

The Board finds that this issue is similar to the issue raised concerning the family practice residents. The Board acknowledges the Provider's assertion that internal medicine residents had to return from non-provider sites for on-site patient care duties and that documentation of on-call schedules support this assertion. The Board, however, agrees with the Intermediary that in order to claim this additional time, the Provider needs to have detailed time records for all of the residents' time. The Board finds that without

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[5] Provider's Request to File Supplemental Authority, letter dated October 25, 2005.

[6] See Glossary at ACGME website at www.acgme.org/adspublic/glossary/glossary.asp.
Sponsoring Institution: The institution (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. **Major Participating Institution:** An RRC-approved participating institution to which the residents rotate for a required educational experience. Generally, to be designated as a major participating institution, in a 1-year program, residents must send at least 2 months in a required rotation; in a 2-year program, the rotation must be 4 months; and in a program of 3 years or longer, the rotation must be at least 6 months. RRCs retain the right to grant exceptions to this formula. (See individual Program Requirements.) While the directory lists the Provider's St. Francis campus as a "major participating institution," this only means that a rotation at this institution is a requirement of the program. See Glossary at Id.

detailed time records, the Intermediary's use of rotation schedules for the FTE count was proper.

c) Exclusion of psychiatric rotations for clinical research activities from IME FTE Count

The Provider seeks to include the time spent by two psychiatric residents in a rotation involving clinical research activities. The Intermediary disallowed this rotation for inclusion in IME FTE count because it believed the residents were engaged in laboratory or bench research instead of direct patient care, and there was a lack of auditable documentation concerning what the residents were doing and where these activities were taking place. The Provider contends that the residents were engaged in direct patient care, but even if they were not, the regulation at 42 C.F.R. §412.105(g) does not require that the residents be engaged in patient care.

The Board agrees with the Provider that the regulation does not require direct patient care for the time to be counted. See Riverside, supra. The Board, however, agrees with the Intermediary that the Provider has not presented sufficient documentation regarding the location of the research activity. The Provider presented a letter from the University of Kansas School of Medicine and a list of publications that resulted from these rotations, but no evidence to substantiate the location of these research activities. The Board notes that it is possible that this psychiatric research took place in the non-PPS psychiatric unit of the hospital which is not allowable for inclusion in IME FTE count. The burden of proof is on the Provider to clearly document where this research took place before it can be allowed.

The Board notes that the Intermediary excluded a 3-month time period for Dr. Catterson while he was engaged in a "Com.Psych" rotation. The Intermediary claims that the Provider has not presented any auditable evidence to indicate whether this rotation took place at the hospital or off-site. The Provider claims that half of this time period was spent off-site but that the other half was spent at the hospital and should be counted. The Board finds that there is insufficient documentation to indicate how much of this time was spent at the hospital and whether the time at the hospital was spent in a PPS unit.

DECISION AND ORDER:

a) Family practice rotations to the continuity of care clinic

The Board finds that the Intermediary's use of rotation schedules for the FTE count for family practice residents was proper. The Intermediary adjustments are affirmed.

b) Internal medicine rotations to the St. Joseph campus of the Provider

The Board finds that the residents in the St. Joseph campus internal medicine rotation were in an approved program and that their time should be included in the FTE count. The Intermediary adjustments removing this time are reversed.

The Board finds that the Intermediary's use of rotation schedules for the FTE count for internal medicine residents was proper. The Intermediary adjustments are affirmed.

c) Exclusion of psychiatric rotations for clinical research activities from IME FTE Count

The Board finds insufficient evidence to support the Provider's claim. The Intermediary adjustments are affirmed.

The Board also finds that there was insufficient documentation to support the Provider's claim regarding the three months Dr. Catterson spent in a Com. Psych rotation.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

DATE: May 9, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson