PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D9

PROVIDER –
St. Luke Community Healthcare
Ronan, Montana

Provider No.: 27-1325

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING –
June 12, 2008

Cost Reporting Period Ended -
December 31, 2004

CASE NO.: 07-1153

INDEX

ISSUE:

Whether the Intermediary's disallowance of the Provider's certified registered nurse anesthetist (CRNA) on-call costs was proper.

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 and 413.24.

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 portion 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 reasonable cost reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services. 42 C.F.R. §413.70 provides that providers designated as Critical Access Hospitals will be paid reasonable cost for patient services to Medicare beneficiaries.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Luke Community Healthcare Network (Provider) is a critical access hospital (CAH) located in Ronan, Montana. For its cost reporting period ended December 31, 2004, the Provider furnished CRNA services to Medicare beneficiaries through a contract with an outside supplier. Noridian Administrative Services (Intermediary) reviewed the CRNA contract and determined that a portion of the payments made by the Provider were for

"on-call" services and disallowed them.[1] In part, the Intermediary relied upon 42 C.F.R. §413.70, Payment for services of a CAH and, in particular, 42 C.F.R. §413.70(b)(4), Costs of certain emergency room on-call providers, which states: "the reasonable costs of outpatient CAH services . . . may include amounts for reasonable compensation and related costs for an emergency room physician who is on call. . . ."

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $29,697.[2]

The Provider was represented by Michael R. Bell, CPA. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that on-call costs associated with CRNA services are allowable program expenses in accordance with 42 U.S.C. §1395x(v)(1)(A).[3] In part, the statute states that "standby" costs are allowable unless they are found to be "unnecessary in the efficient delivery of services. . . ." The Provider also cites 42 C.F.R. §413.5, Cost reimbursement: General. stating: "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized" and 42 C.F.R. §413.9(c)(3), which states in pertinent part: "[r]easonable cost includes all necessary and proper expenses incurred in furnishing services. . . . It includes both direct and indirect costs and normal standby costs."

The Intermediary contends that the pertinent statute, 42 U.S.C. §1395x(v)(1)(A), indicates that not all standby costs are necessary in the efficient delivery of health care services. In the context of the statute, the Secretary promulgated 42 C.F.R. §413.5 and §413.9 and CMS Pub. 15-1 §2102.1, allowing standby costs in certain circumstances which include costs associated with unoccupied beds and the allocation of costs between certified and non-certified beds (CMS Pub. 15-1 §2342), and assets that have been retired but held for emergency use (CMS Pub. 15-1 §130).[4] With respect to CAHs, 42 C.F.R. §413.70(b)(4) allows standby costs associated with emergency room physicians and midlevel practitioners which does not include CRNAs. The Intermediary argues that "CRNA's standby cost is not covered by the instructions, and as a result [Medicare] does not recognize it as the normal standby cost under §413.9."[5]

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[1] Intermediary's Position Paper at 4.
[2] Provider's Position Paper at B. Issue in Dispute. See also Exhibit P-3
[3] Although standby costs associated with nurses, laboratory technicians, and other hospital staff are not at issue in this case, the Provider asserts that these individuals are routinely paid for standby time and these costs have never been questioned by the Intermediary. Provider's Position Paper at 3. See also Addendum to Provider's Position Paper at 1.
[4] Transcript (Tr.) at 24.
[5] Tr. at 26.

The Provider also contends that the Intermediary's reliance upon 42 C.F.R. §413.70(b)(4)(ii)(B), and Medicare's Provider Reimbursement Manual, Part I (CMS Pub. 15-1) §2109, to disallow the subject on-call costs is in error. These authorities apply to emergency room physicians and midlevel practitioners and do not reduce or replace Medicare's reasonable cost reimbursement rules that apply to CRNA costs incurred by CAH.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

There is no statute, regulation or guideline which specifically addresses whether CRNA standby costs incurred by a CAH are allowable. However, there are several authorities which, when read together, provide for the payment of CRNA standby costs. These provisions are as follows:

- 42 U.S.C. §1395x(v)(1)(A) recognizes that standby costs may be reasonable or necessary costs. The Act instructs that the Medicare reasonable cost regulations shall "take into account both direct and indirect costs of the provider of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services . . .)" (emphasis added)

- The reasonable cost regulation at 42 C.F.R. §413.9(c)(3), also refers to "normal standby" cost. The regulation reads: "The determination of reasonable costs of services must be based on cost related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper expenses incurred in furnishing services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs." (emphasis added)

- CMS Pub. 15-1 §2102.1 also includes the term standby costs in its discussion of reasonable costs: "Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs." (emphasis added)

The Board finds nothing in the above references that specifically precludes standby costs from being included in reasonable cost. The Board concludes that the statute, regulations and program instructions contemplate that normal standby costs are considered reasonable costs. Therefore, the Intermediary's conclusion that the controlling reasonable cost principles allow only those standby costs that are specifically identified as allowable is without merit.

The Intermediary relied on 42 C.F.R. §413.70, Payment for services of a CAH, to support its position that CRNA standby costs are not specifically identified as "allowable," therefore, they must be "non-allowable." The section of the regulation the Intermediary

argues is pertinent to this case, 42 C.F.R. §413.70(b)(4), entitled Costs of certain emergency room on-call providers, is specific to on-call providers in an emergency room setting.[6] The Board finds that the evidence in this case is consistent with what the Board understands to be typical of CRNA services, which is that generally, CRNAs would not work in an ER setting.[7] (See, e.g., Marias Medical Center v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Montana, PRRB Dec. No. 2008-D40, September 29, 2008, rev'd, CMS Administrator, November 21, 2008, where the Board found that less than 1% of CRNA services were performed in the emergency room.) Therefore, CRNAs would not be considered emergency room personnel under 42 C.F.R. §413.70(b)(4) and this regulation would not apply to CRNA standby services.

As the Board has found that 42 C.F.R. §413.70(b)(4) does not apply and therefore does not preclude the Provider from claiming CRNA standby costs, the Board looks to 42 C.F.R. §412.113(c) which specifically allows CAHs to use CRNAs and to be paid on a reasonable cost basis. The Provider has maintained that it met all the requirements for the reimbursement of reasonable costs for CRNA services, which in this specific case included services provided under arrangement and included standby costs.[8] The Provider also asserts that contracting with a CRNA to provide services under arrangement, including paying standby costs, actually saved the Provider money when compared to hiring a CRNA on staff. The Board finds that both 42 C.F.R. §413.9 and CMS Pub.15-1 §2102.1, attempt to limit expenditures. CMS Pub. 15-1 §2102.1 reads:

> Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do no exceed what a prudent and cost conscious buyer pays for a given item or service. (See §2103). If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

The Board finds that the Provider's business decision to use a contracted CRNA and incur the standby costs at issue was an attempt to limit its costs and pay only what a "prudent and cost conscious buyer" would pay for CRNA services. Therefore, these standby costs met the reasonable cost standards of 42 C.F.R. §413.9 and PRM §2102.1 and the costs are allowable.

Finally, the Board finds no evidence that it was "longstanding" CMS policy to never allow unspecified standby costs, and finds support in the statute, regulations and program

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[6] The Board also notes the portion of the regulation that contains the list of emergency room providers (e.g., emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist) cited herein was not effective until January 1, 2005, the year after the year appealed.

[7] The Intermediary concurs that "CRNAs typically aren't working in the emergency room or providing on-call emergency services." Tr. at 30.

[8] Tr. at 13-14.

instructions that the opposite is true provided the standby costs were reasonable and necessary. This finding is further supported by the Provider's testimony that the hospital is routinely cost reimbursed for other types of employee and contractor standby costs, such as laboratory staff and radiology technicians despite there being no specific reference to these standby services.[9] The Board finds that since the CRNAs who meet the requirements of 42 C.F.R. §412.113(c) are paid on a reasonable cost basis, their standby costs would be reimbursed similarly to these other hospital staff.

DECISION AND ORDER:

The Intermediary improperly disallowed the standby costs incurred by the Provider for contracted CRNA services. The Intermediary's disallowance is reversed.

Board Members Participating:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: February 25, 2009

[9] Tr. at 36-39