PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2019-D12

PROVIDER-
Dukes Memorial Hospital

Provider No.: 15-1318

vs.

MEDICARE CONTRACTOR -
WPS Government Health Administrators

HEARING DATE -
August 3, 2017

Cost Reporting Periods Ended -
December 31, 2009 & December 31, 2010

CASE NOs. - 13-0252 & 14-3256

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor appropriately disallowed costs to the Provider claimed for physician compensation for emergency room availability services (frequently referred to as "standby services"), administrative/management services, and on-call costs.[1]

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds:

1. The Medicare Contractor properly disallowed on-call physician costs related to the contracts with Dr. Mull, Dr. Lorenz, and Advanced Orthopedics for fiscal years ("FYs") 2009 and 2010.

2. The Medicare Contractor improperly disallowed the Emergency Medicine of Indiana ("EMI") costs for FYs 2009 and 2010.

Accordingly, the Board remands these cost reports back to the Medicare Contractor with instructions to include the following EMI payments as allowable costs of the Provider: (a) the minimum guarantee payments made by the Provider to EMI for FYs 2009 and 2010; and (b) the Medical Director payments made by the Provider to EMI for FY 2010.

INTRODUCTION:

Dukes Memorial Hospital ("Dukes Memorial" or "Provider") is a Critical Access Hospital ("CAH") located in Peru, Indiana. Dukes Memorial's designated Medicare Administrative Contractor is WPS Government Health Administrators ("Medicare Contractor").[2] The Medicare Contractor disallowed costs that Dukes Memorial claimed related to four contracts for physician services – Emergency Medicine of Indiana ("EMI"), Dr. Mull, Dr. Lorenz and Advanced Orthopedic - for FYs 2009 and 2010.[3]

Dukes Memorial timely appealed the Medicare Contractor's adjustments to the Board and met the jurisdictional requirements for a hearing. The Board conducted a hearing on August 3, 2017. Dukes Memorial was represented by Mark Polston, Esq. of King and Spalding, LLP. The Medicare Contractor was represented by Joe Bauers, Esq. of Federal Specialized Services.

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[1] Transcript ("Tr.") at 7.

[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.

[3] Provider's Post-Hearing Brief at 1; Tr. at 22-24.

STATEMENT OF FACTS

The Critical Access Hospital designation was established by the Balanced Budget Act of 1997[4] in order to improve access to healthcare for rural and underserved areas.[5] To be eligible as a CAH, a facility must meet certain requirements, including certain status and location requirements, and also must make available emergency care services. More specifically, the requirements at 42 U.S.C. § 1395i-4 include:

> **(B) Criteria for designation as critical access hospital**
> A State may designate a facility as a critical access hospital if the facility--
> (i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1395ww(d)(2)(D) of this title) or is treated as being located in a rural area pursuant to section 1395ww(d)(8)(E) of this title, and that--
> (I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or
> (II) is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area;
> (ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;
> (iii) provides not more than 25 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;
> (iv) meets such staffing requirements as would apply under section 1395x(e) of this title to a hospital located in a rural area . . .
> (v) meets the requirements of section 1395x(aa)(2)(I) of this title.[6]

The nature of a CAH is that it is a low volume provider located in a rural area, which can make it difficult to attract the necessary physicians to staff the hospital.[7] Given this set of circumstances, the applicable regulations and manual provisions allow for different types of contract arrangements to allow for CAHs to be sufficiently staffed, including on-call and availability services arrangements.

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[4] Pub. L. No. 105-33, § 4201, 111 Stat. 251, 369 (1997).
[5] *See* 62 Fed. Reg. 45966, 46009 (Aug. 29, 1997).
[6] 42 U.S.C. § 1395i-4(c)(2)(B).
[7] Provider's Final Position Paper at 1 (FY 2009).

One of the statutory requirements of a CAH is that it "makes available 24-hour emergency care services. . ."[8] Prior to October 1, 2001, ERs had to be staffed by a physician that was on-site 24 hours a day. However, taking into account the low volume and staffing difficulties of a CAH, regulations were promulgated, effective October 1, 2001, to allow for a CAH ER to be staffed by an on-call physician.[9] The regulation at 42 C.F.R. § 413.70(b)(4)(i) provides:

> Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at another other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at another other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.[10]

As a CAH, Dukes Memorial is reimbursed for inpatient and outpatient services on a reasonable cost basis.[11] The Medicare statute defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services[.]"[12] The intent of the reasonable cost statute, which has been in place since the beginning of the Medicare program in 1965, is "to meet the actual costs" incurred in rendering necessary services, "including normal standby costs."[13] Under this fundamental precept, a provider's actual incurred costs may be nonetheless limited when "a particular institution's costs are found to be substantially out of line with those of institutions similar in size, scope of services, utilization, and other relevant factors."[14]

Consistent with Congressional intent to reimburse CAHs for their actual costs incurred, the implementing reasonable cost reimbursement regulation provides that "reasonable cost" includes

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[8] 42 U.S.C. § 1395i-4(c)(2)(B)(ii).
[9] 66 Fed. Reg. 39828, 39922-39923 (Aug. 1, 2004).
[10] (effective Oct. 1, 2004).
[11] *See* 42 U.S.C. §§ 1395f(l)(1), 1395m(g)(1); 42 C.F.R. §§ 413.70(a)(1), (b)(2)(i).
[12] 42 U.S.C. § 1395x(v)(1)(A).
[13] S. Rep. No. 89-404, at 35-36 (1965) (*available at* https://www.finance.senate.gov/imo/media/doc/SRpt89-404.pdf).
[14] Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2102.1 ("It is the intent of the program that providers are reimbursed the actual costs of providing high quality care, regardless of how widely they may vary from provider to provider, except where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.").

"all necessary and proper costs incurred in furnishing the services[.]"[15] The regulation broadly defines the term "necessary and proper costs" to mean "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities."[16] And, again consistent with the intent of the statute, the implementing regulations include "standby costs" and "administrative costs," including the certain costs of physician services provided to the hospital, rather than directly to an individual patient, within the definition of reasonable costs.[17]

While CAHs are subject to the regulatory reasonable cost calculation methodologies, these providers have been granted certain exceptions and exclusions from those calculation methodologies. For example, the reasonable compensation equivalent ("RCE") test for reasonableness of physician service costs to providers does not apply to CAHs.[18] Similarly, the regulations expressly define reasonable costs in a CAH to "include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved," so long as the emergency room physician "is not otherwise furnishing physicians' services, and is not on call at any other provider or facility."[19] Thus, reimbursement to CAHs for the services of emergency room physicians may include both on-call costs and standby costs, provided that these services are furnished consistent with regulatory requirements.

In an on-call arrangement, the physician is not on the hospital premises; whereas, in an availability or standby arrangement,[20] the physician is onsite at the hospital and available to render services. PRM 15-1 offers additional explanation regarding availability services, and how they are reimbursed. In this regard, PRM 15-1 § 2109 provides:

> 2109.1 General.--Wide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an availability status awaiting the arrival of patients. Alternatively, hospitals may need to arrange for emergency department physician coverage for evenings, weekends or holidays, when staff or community physicians are not available. Since these periods frequently generate inadequate physician revenue through charges for professional services due to lower utilization, hospitals may

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[15] 42 C.F.R. § 413.9(a).
[16] 42 C.F.R. § 413.9(b)(2).
[17] 42 C.F.R. § 413.9(c)(3); *see also* 42 C.F.R. § 413.5(a) (stating that payment on a reasonable cost basis is meant to include "[a]ll necessary and proper expenses of an institution in the production of services, including normal standby costs[.]"). 42 C.F.R. § 415.55(a).
[18] 42 C.F.R. §§ 413.70(a)(1)(iii), (b)(2)(i)(B).
[19] 42 C.F.R. § 413.70(b)(4)(i).
[20] "Standby" and "availability" are terms that are used interchangeably. *See, e.g.*, 66 Fed. Reg. at 39922 ("[c]onsistent with the general policies stated in section 2109 of the Medicare Provider Reimbursement Manual (PRM), Part I (HCFA Publication 15-1), the reasonable cost of CAH services to outpatients may include reasonable costs of compensating physicians who are on standby status in the emergency room (that is, physicians who are present and ready to treat patients if necessary).").

> have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments.
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> When emergency department physicians are compensated on an hourly or salary basis or under a minimum guarantee arrangement (§2109.2E) providers may include a reasonable amount in allowable costs for emergency department physician availability services subject to limitation through the application of Reasonable Compensation Equivalents (RCEs). Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section. ***
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> 2109.2 Definitions.—
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> ***
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> E. Minimum Guarantee Arrangement.--A minimum guarantee arrangement is a financial arrangement between a physician or a group of physicians and a provider where the physician(s) is (are) guaranteed a minimum level of compensation (the minimum guarantee amount) for availability services. The physician(s) may receive more than the minimum amount guaranteed if they generate charges for services to individual patients in excess of the minimum guarantee amount. If the charges fall short of the minimum guarantee amount, the provider is obligated to pay the physician(s) the difference to make up the guaranteed amount. A minimum guarantee arrangement may also contain provisions for compensating physicians for performing provider services such as supervision of the emergency department, administration, etc.

The calculations in PRM 15-1 § 2109 use RCEs to determine the reasonable costs paid for standby services. The regulations, as noted previously, do not require CAHs to apply RCEs in reasonable cost calculations. As a result, in the case of a CAH, other means, outside of using RCEs, need to be applied to determine if the standby costs paid are reasonable.

In this appeal, Dukes Memorial contracted with EMI to have physicians present in the hospital 24 hours a day and has guaranteed a minimum payment of a fixed amount per month.[21] In addition, Dukes Memorial contracted with Drs. Mull and Lorenz, who provide Pediatric on-call coverage, and Advanced Orthopedics to provide orthopedic on-call coverage.[22] Both the EMI contract, which relates to standby services, and the on-call costs were disallowed by the Medicare Contractor and are under dispute in this appeal.[23]

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[21] Provider's Final Position Paper (FY 2009) at 5-6.
[22] *Id.* at 7.
[23] Provider's Post-Hearing Brief at 1; Tr. at 22-24.

FINDINGS OF FACT, CONCLUSION OF LAW, AND DISCUSSION

Dukes Memorial entered into four contracts for on-call and availability services during the fiscal years under appeal—FYs 2009 and 2010. It claimed these on-call and availability costs are reasonable hospital costs under Medicare Part A. The Medicare Contractor disallowed these costs for three reasons: (1) the on-call services did not specifically relate to ER-related services; (2) Dukes Memorial lacked adequate documentation that "alternative options" were explored prior to entering into the contracts; and (3) Dukes Memorial lacked support of the time studies allocating the split between Part A (services provided to the hospital) and Part B (services provided directly to individual patients). Dukes Memorial argues that the Medicare Contractor's reasons for the disallowances are either wrong or based on misunderstandings regarding the Medicare rules. [24]

Emergency Medicine of Indiana ("EMI") Contract

For the cost years at issue, Dukes Memorial contracted with EMI to provide emergency medicine physician services in the Dukes Memorial emergency department 24 hours a day, 365 days per year.[25] These emergency room services were provided at the facility and were comprised of both coverage and availability/standby services.[26] Dukes Memorial compensated EMI under a minimum guarantee arrangement.[27] Specifically, EMI billed for the services provided to patients, and, when the collections for those services did not meet the monthly amount guaranteed under the contract, Dukes Memorial would pay EMI the difference.[28] In addition, the EMI contract included Medical Director services of at least 20 hours per month, which were paid by a flat monthly fee.[29]

The Medicare Contractor disallowed the minimum guarantee payments made by Dukes Memorial to EMI for both FY 2009 and FY 2010. These payments were disallowed because Dukes Memorial was not able to split the allowable and non-allowable costs on the cost report, and because there was no evidence or documentation that other options were adequately explored before Dukes Memorial entered into the EMI contract.[30] In addition, the Medicare Contractor disallowed the Medical Director payments made to EMI for only one of the two fiscal years, specifically FY 2010.

The Medicare Contractor points out that Medicare makes a distinction between services rendered by a physician directly for a patient (not allowable costs on the cost report) and administrative physician services rendered to the hospital (allowable costs on the cost report). Specifically, 42 C.F.R. § 415.60 requires providers to allocate physician compensation costs between services to

[24] Provider's Final Position Paper (FY 2009) at 2-3.
[25] Exhibit P-11 (FY 2009) at 17.
[26] *Id.* at 18.
[27] *Id.*
[28] Provider's Post-Hearing Brief at 16. The guarantee payment was $110,000 per month through March 2010 when it increased to $110,725 per month. Exhibit P-11 (FY 2009) at 4, Exhibit P-35 (FY 2009) at 11.
[29] Exhibit P-11 (FY 2009) at 18-19. Note – this flat rate was changed to $4000 per month in October 2007. *See* Exhibit P-12 (FY 2009) at 25, 36.
[30] Medicare Contractor's Post-Hearing Brief at 6-7.

the provider, services to the patient, and other services.[31] The Medicare Contractor asserts that Dukes Memorial cannot use its Tracker system to determine patient care hours because the system only tracks the time spent in the patient's room and does not include the time the physician spent reading tests, updating charts, or other patient care activities.[32]

The Board disagrees. Although the Tracker system may not be perfect, the Board finds that the Tracker system used by Dukes Memorial adequately supported the split of EMI physician costs between services to Dukes Memorial and services to the patient. At the hearing, Dukes Memorial's witness explained the Tracker system was specifically designed for CAHs and monitors when a physician is in a patient's room and when the physician is in the central station.[33] Additionally, the witness explained that each patient care room has a point of service computer so that a physician can do things like chart progress for a patient, assessments, or review lab results in the room with the patient.[34] Accordingly, the Board finds that Dukes Memorial's use of the Tracker system is sufficient to establish the split between services to Dukes Memorial and services to a patient.

Similarly, the Board finds that Dukes Memorial did, in fact, show that alternative options were adequately explored before entering into the EMI contract. At the hearing, a witness for Dukes Memorial explained how Dukes Memorial assessed its needs and decided to enter into the contract with EMI. The witness explained that Dukes Memorial tried to use different emergency medicine groups and tried to contract independently with physicians to provide coverage.[35] The witness explained that it is typical for rural communities to have physicians come and go, which would mean that there would be lapses in coverage and the emergency department would not be able to operate 24 hours a day, 7 days a week.[36] In addition, the witness testified that Dukes Memorial also submitted requests for proposals to other groups before deciding to enter into the contract with EMI.[37] The Board finds that this is sufficient to establish that Dukes Memorial appropriately and adequately explored alternative methods for obtaining emergency physician coverage before agreeing to contract with EMI for ER physician services.

Finally, the Board finds that Dukes Memorial's claimed standby costs appear reasonable. Specifically, the Provider computed its FY 2009 standby hours to be 8001 by subtracting the 759 patient service hours reported by the Tracker system from the total contract hours of 8760 (365 days times 24 hours per day). When the minimum guarantee payment amount for FY 2009 of $248,827 is divided by the total standby hours of 8001, this computes to an average hourly rate of $31 an hour.[38] The Board finds $31 per hour to be reasonable standby compensation, especially when it is compared to the Internal Medicare physician RCE average hourly wage of $72.21.[39] As the FY 2010 minimum guarantee payment to EMI was similar to the FY 2009 payment (the Provider claimed EMI costs, including Medical Director costs, of $258,509 on its

[31] Medicare Contractor's Final Position Paper (FY 2009) at 14.
[32] *Id.* at 13.
[33] Tr. at 71; *see also* Exhibit P-21 (FY 2009) (showing examples of the Tracker System data).
[34] Tr. at 72.
[35] *Id.* at 51.
[36] *Id.* at 51-52.
[37] *Id.* at 52-53.
[38] Exhibit P-10 (FY 2009).
[39] *See id.* (identifying $150,200 as the Internal Medicine RCE ($150,200/2080 = $72.21)).

FY 2010 cost report),[40] the Board concludes that the minimum guarantee payments made to EMI for FYs 2009 and 2010 were reasonable, necessary, and allowable costs for Dukes Memorial.

Finally, with respect to the FY 2010 Medical Director costs, the Board finds that they should also be treated as allowable administrative costs. The Board notes that the Medicare Contractor had reviewed the very same Medical Director costs for FY 2009 and found that they *were* allowable administrative costs of Dukes Memorial for FY 2009. The description of the EMI Medical Director services is a Medicare allowable activity and there is nothing in the record which suggests that the FY 2010 Medical Director costs were any different than those for FY 2009 to justify disparate treatment between FYs 2009 and 2010.[41]

The Board remands these cost reports back to the Medicare Contractor to include as allowable cost of Dukes Memorial the following: (1) the minimum guarantee payments made by Dukes Memorial to EMI for FYs 2009 and 2010; and (2) the Medical Director payments made by Dukes Memorial to EMI for FY 2010.

Contracts with Doctors Mull and Lorenz

In addition to the EMI contract, Dukes Memorial contracted with Dr. Mull and Dr. Lorenz "to provide Pediatric Call Coverage services."[42] Schedule A of the contracts indicates that the physician is responsible for "Scheduled, as needed Pediatric call coverage" for "One weekend per month from close of business on Friday to start of business on Monday. This constitutes 2.6 shifts per weekend."[43] Schedule B of the contract states that the physician will be paid $1000 per shift. Additionally, the physician can independently bill and receive payment for the services provided to the patients.[44]

Under these contracts, the physician is on-call, but not physically present at Dukes Memorial's facility unless called in for services.[45] The regulation at 42 C.F.R. § 413.70(b)(4) governs on-call costs and states that effective October 1, 2001, the reasonable cost of outpatient CAH services may include certain emergency room physician on-call costs.[46] This regulation is very specific in the use of the language "emergency room" and "outpatient," and denotes that the on-call services must be related to the emergency room. As the Secretary has explained in the Federal Register, this language clearly excludes on-call services performed in the inpatient areas of the hospital or in non-emergency room outpatient settings.[47]

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[40] *See* Exhibit P-21 (FY 2010).
[41] *See* Medicare Contractor's Final Position Paper (FY 2010) at 13-14 where the Medicare Contractor agrees the Provider documented 4 months of the Medical Director's duties were for administrative and general services and therefore payable. The Board finds there's sufficient evidenced in the record to support all of the claimed Medical Director payments for FY 2010.
[42] Exhibits P-4, P-6 (FY 2009); *see also* Provider's Post-Hearing Brief at 19 (stating the contracts with Dr. Mull and Dr. Lorenz are identical contracts).
[43] Exhibit P-4 (FY 2009) at 12; Exhibit P-6 (FY 2009) at 12.
[44] Exhibit P-4 (FY 2009) at 13; Exhibit P-6 (FY 2009) at 13.
[45] Provider's Final Position Paper at 7 (FY 2009).
[46] 42 C.F.R. § 413.70(b)(4)(i).
[47] In preambles to final rules published in the Federal Register, CMS has been clear that physician on-call costs are only allowable in the emergency room setting. For example, in the preamble to the May 12, 1998 final rule, CMS made clear that no payment for on-call physician costs was available to hospitals, regardless of where the on-call

In the *St. Luke Community Health Care* case,[48] the Secretary enforced this regulation again making it clear that emergency room on-call physician expenses are the only reimbursable on-call costs in a CAH. The court in its decision stated "[t]he Secretary's decision construes the Medicare provisions at issue to identify emergency room physician on-call costs as the only on-call costs that are reimbursable under Medicare. This interpretation is not contrary to the plain language of the regulation, and the Court must defer to the Secretary's 'exercise of judgment grounded in policy concerns' seeking to prevent the Medicare program from bearing the costs associated with matters not covered by Medicare."[49]

Doctors Mull and Lorenz each stated the following in their respective declarations:

> Under this arrangement, I was on-call but not physically present at the Provider. I was available solely to the Provider for the Provider's emergency room services and not on-call at any other facility, and I did not provide physician services elsewhere while on-call.[50]

However, the Board notes that the contracts do not state that the on-call services are for the ER only. Rather, the contracts state "as needed Pediatric call coverage."[51] At the hearing, Dukes Memorial's witness testified that "if there were any issues in our nursery, our newborn nursery, they would address those issues, they [Dr. Mull or Dr. Lorenz] would be the attending physician."[52] Additionally, the witness testified that Dukes Memorial "post[s] the on-call schedules in the emergency department, in the medical floors, and in the OB department so everyone is aware who the on-call physicians are."[53] The Board finds that the testimony and contracts are credible evidence that these physicians provided services to areas other than the ER.

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services were rendered. *See* 63 Fed. Reg. 26318, 26353 (May 12, 1998) ("As is the case for full-service hospitals, standby costs of emergency room physicians who are present at the emergency room are allowable costs and will, to the extent they are reasonable in amount, be taken into account in computing Medicare payment. However, Medicare does not recognize costs of "on-call" physicians as allowable costs of operating a CAH." (emphasis added)). Similarly, in the preamble to the August 1, 2001 final rule, CMS discusses the implementation of 42 C.F.R. § 413.70(b)(4) and states that, under existing policy, the reasonable cost of CAH services to outpatients may *not* include any costs of compensating physicians who are not present in the facility but on call. *See* 66 Fed. Reg. 39829, 39922-39923 (Aug. 1, 2001). At that time, CMS added a new paragraph (4) to § 413.70(b) to "permit the reasonable costs of CAH outpatient services to include the reasonable compensation and related costs of emergency room on-call physicians under the terms and conditions specified in the statute." *Id.* at 39923. The August 1, 2001 preamble makes it clear that the intent of 42 C.F.R § 413.70(b)(4) is to only reimburse reasonable physician on-call costs that are related to the emergency room and not in other outpatient settings.

[48] *St. Luke Cmty. Health Care v. Sebelius*, No. CV 09-92-M-DWM-JCL, 2010 WL 1839411 (D. Mont. Apr. 14, 2010), *adopted by*, 2010 WL 1839405 (D. Mont. May 5, 2010).

[49] *Id*. at 11.

[50] Exhibits P-24, P-25 (FY 2009).

[51] Exhibit P-4 (FY 2009) at 11; Exhibit P-6 (FY 2009) at 12.

[52] Tr. at 78; *see also* Tr. at 81 ("Q: So these were not in addition to emergency services, these are just the on-call [pediatric specialty] services to supplement what Dukes already had? A: Right.").

[53] Tr. at 93.

The Board concludes that the on-call services provided to Dukes Memorial under these contracts were not limited to the ER, but were provided for other non-emergency areas of the hospital and therefore do not meet the requirements of 42 C.F.R. § 413.70(b)(4). Therefore, the Medicare Contractor was correct in disallowing Dukes Memorial's costs for the contracts with Dr. Mull and Dr. Lorenz.

Contract with Advanced Orthopedic Care

The fourth contract at issue in this appeal is between Dukes Memorial and Advanced Orthopedic Care. The contract is a flat fee arrangement for services to be performed by five orthopedic physicians, on a rotating basis, for three categories of service: emergency on-call services, coverage of the hospital's orthopedic clinic, and coverage of the hospital's orthopedic surgeries.[54] Specifically, the contract required regular in-house orthopedic coverage, including clinical and surgical, 4.5 hours per day, 4 days a week, and on-call coverage 24 hours a day/7 days a week.[55] Dukes Memorial paid a flat fee to Advanced Orthopedic Care for its services. Unlike the other contracts in this case, the orthopedic physicians did not bill and collect for their services. Rather, Dukes Memorial billed for and collected the payment for the orthopedic services.[56]

Dukes Memorial calculated that approximately 90 percent of the time under this contract related to on-call time, and believes it should be able to claim approximately 90 percent of the cost of the contract as on-call emergency room costs.[57] The Board disagrees. While the contract is clear that the fee paid to Advance Orthopedic Care is to cover on-call time as well as clinic and surgery time, there is no documentation on how this fee was derived or how it should be split between the various categories of services provided. Dukes Memorial's method of determining the cost for on-call services is to allocate the amount paid to Advanced Orthopedic Care based on hours, resulting in the same hourly cost for each category of service. The Board finds no support in the record or otherwise for this methodology and finds it is not reasonable that Advanced Orthopedic Care would charge, and that Dukes Memorial would pay, the same hourly rate for a physician performing surgery or working in a clinic, as it charges or pays for a physician that is on-call, and not even at Dukes Memorial's location.

Furthermore, there is nothing in the contract with Advanced Orthopedic Care that indicates the services are for ER care. Rather the contract states "providing reasonable professional orthopedic services at the Facility to all patients who seek such orthopedic services[.]"[58] Similar to the contracts with Doctors Mull and Lorenz, the on-call time included in the contract with Advanced Orthopedic must meet the requirements of 42 C.F.R. § 413.70(b)(4), which allows compensation to a CAH only for ER on-call providers. As the Advanced Orthopedic Care contract relates to "all patients who seek such orthopedic services," it is clear that this would include non-emergency care as well as emergency care.

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[54] Exhibit P-8 (FY 2009); *see also* Tr. at 108-111.
[55] Exhibit P-8 (FY 2009) at 10.
[56] *Id.* at 11.
[57] Dukes Memorial claimed $669,864, or 89.32 percent, of the $750,000 paid under the contract. Exhibit P-21 (FY 2010) at 3*; see also* Exhibit P-10 (FY 2009) (showing how the Provider calculated the 89.32 percent that it used).
[58] Exhibit P-8 (FY 2009) at 9.

The Board concludes that the Medicare Contractor was correct in disallowing the cost for the Advanced Orthopedic Care contract as Dukes Memorial did not adequately document the cost for the on-call services, did not demonstrate that the on-call costs were reasonable, and did not demonstrate that the on-call services claimed were for ER costs.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds:

1. The Medicare Contractor properly disallowed on-call physician costs related to the contracts with Dr. Mull, Dr. Lorenz, and Advanced Orthopedics for FYs 2009 and 2010.

2. The Medicare Contractor improperly disallowed the EMI costs for 2009 and 2010.

Accordingly, the Board remands these cost reports back to the Medicare Contractor with instructions to include the following EMI payments as allowable costs of Dukes Memorial: (a) the minimum guarantee payments made by Dukes Memorial to EMI for FYs 2009 and 2010; and (b) the Medical Director payments made by Dukes Memorial to EMI for FY 2010.

BOARD MEMBERS PARTICIPATING:

Charlotte F. Benson, CPA
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FOR THE BOARD:

1/28/2019

X Charlotte F. Benson

Charlotte Benson, CPA
Board Member
Signed by: PIV