CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
St. Benedicts Family Medical Center **Provider** **vs.** **Blue Cross/Blue Shield Association** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/00** **Review of:** **PRRB Dec. No. 2007-D10** **Dated: December 15, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f) (1) of the Social Security Act (Act) [42 USC 1395oo (f) (1)], as amended. Comments were received from the Provider requesting that the Board's decision be reversed. The Administrator notified the parties of his intent to review. Comments were received from Intermediary and the Centers for Medicare Management (CMM), requesting clarification of the Board's decision. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

As a preliminary matter, the Board found that it had jurisdiction over the emergency room availability issue because the amount in controversy meets the $10,000 threshold, the appeal was timely filed and the Provider claimed these costs in correspondence filed prior to the issuance of the Notice of Program Reimbursement (NPR), which was subsequently denied by the Intermediary. Two Board members dissented without opinion.

The substantive issue before the Board was whether the Provider's physician assistant emergency room availability costs[1] are allowable as Medicare Part A reimbursable expenses.

The Board affirmed the Intermediary's adjustment, stating that the Intermediary properly denied the Provider's request for emergency room physician availability costs be included in its cost report. The regulation at 42 CFR 415.60(f)(1) states that in order for a provider to be reimbursed for physician compensation costs under Medicare Part A, it must submit a written allocation agreement between the provider and the physicians that specify the respective amounts of time physicians will spend furnishing services to the provider and to patients and other activities non-payable under either Part A or Part B. The Board found that the Provider did not submit an allocation agreement meeting the requirements. The Provider's contract with physician assistants along with documentation submitted with its cost report does not meet the requirements for the submission of an allocation agreement.

The Board found that the Provider's contract does not address, nor otherwise distinguish, availability time from the contractor's responsibility to furnish direct patient care. The only documents submitted addressing physician time was the Provider's cost report reimbursement questionnaire, which allocates 100 percent of physician time to professional services reimbursed under Part B and no time allocated to Part A provider services. The questionnaire was not signed by the physician. The Board acknowledged the time study prepared by the Provider, reflecting almost 50 percent of the physician assistant time spent in non-patient care activities. However, this study by itself does not meet the program requirements for the submission of a properly drafted and executed allocation agreement. The Board noted that in the absence of a written allocation agreement, the regulation at 42 CFR 415.60(f)(2) requires the Intermediary to assume that 100 percent of physician compensation costs are allocated to services furnished to beneficiaries. As the Provider failed to meet this requirement, none of the physician assistant emergency room availability costs was allowable under Medicare Part A.

[1] For purposes of this decision, the Board used the terms "physician assistant" and "physician" interchangeably.

SUMMARY OF COMMENTS

The Provider argued that an allocation agreement that allocates costs attributable to emergency room patient care and availability is not possible. The practitioner and the Provider do not know how much time will be devoted to these two categories of services until after the end of the cost reporting year. The only agreement that can exist in advance is that the practitioner will devote one hundred percent of time to an emergency room department availability to furnish patient care, which is identified in Section B of the employment agreement.

The Provider stated that the regulations assume that the only accurate allocation method must come from information furnished by the practitioner that must be set forth in writing. The practitioner's contractual responsibility is limited to only one thing, devoting one hundred percent of time of being available to furnish patient care in an emergency room. Any allocation of the physician's time between patient care and availability is the Provider's responsibility, and that responsibility is fulfilled through the maintenance of a patient emergency room log that is maintained by the Provider's nursing and other staff.

CMM agreed in part with the Board's decision except as to its characterization that physicians and physician assistants are conceptual equivalents. Regarding reasonable cost reimbursement of emergency room physician availability services, the statute and regulations make clear that physician assistants and physicians are to be considered distinct, rather than as equivalent, practitioners. Covered physician assistant services may be billed only by the individual practitioner's employer, only under Medicare Part B and only under certain conditions in accordance with the provisions of 42 C.F.R. §410.74. CMM stated that it appeared the Provider claimed and received Part B reimbursement prior to requesting reopening of its FYE June 30, 2000 cost report.

The Intermediary requested that jurisdiction be vacated. No regulation exists that would have precluded the Provider from including its physician availability emergency room in a cost report claim and, thus, there was no "self-disallowance" issue. The Intermediary cited to Your Home Visiting Nursing Services v. Secretary, 119 S. Ct. 930 (1999) which ended the Board's ability to review an action based on rejecting a reopening type request; further stating that if the Board treated the case as a review of the Intermediary's refusal to reopen or amend the cost report, there is no legal basis for jurisdiction.

In addition, the Intermediary stated that Board's decision was correct that no costs for physician assistant's emergency room availability is allowable as Medicare Part A expenses. The Board correctly identified a properly completed allocation agreement as an indispensable requirement for allowable Part A emergency room availability costs, and this allocation agreement implements the provisions of the underlying contract. The Intermediary noted that the Provider billed $414,529 for professional services for Part B that exceeded the $390,238 it actually paid in compensation, but that was not a measure of whether the availability costs were payable.

DISCUSSION AND EVALUATION

The record furnished by the Board has been examined, including all correspondence, position papers and exhibits submitted by the parties. The Board's decision has been reviewed by the Administrator. All comments received after entry of the Board's decision have been made a part of the record and have been considered.

After a review of the record and applicable law and policy, the Administrator affirms the Board's decision but on different grounds both with respect to jurisdiction and the merits of the case. The Administrator finds that the Board improperly found jurisdiction on the basis that the Provider "claimed these costs in correspondence filed prior to the issuance of the NPR, which was subsequently denied by the Intermediary."

Section 1878(a)(1) of the Act provides, inter alia, that any provider of services which has filed a required cost report may obtain a hearing with respect to such cost report by the Board if the provider:

> (A)(1) is dissatisfied with the final determination of the intermediary as to the amount of total program reimbursement ... for which payment may be made under this title for the period covered by such report....
> ....
> (2) the amount in controversy is $10,000 or more, and
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> (3) such provider files a request for a hearing within 180 days after the notice of the intermediary's final determination....

Under §1878 of the Act, the Board's jurisdiction is limited to a provider's request for a review of a "final determination" of an intermediary or Secretary for which the said provider is "dissatisfied."[2] The regulation at §405.1801(a)(1) defines "intermediary determination" with respect to the cost reimbursement system, as:

> A determination of the amount of total reimbursement due to the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to the beneficiary for which the reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

In addition, separate from the statutory and regulatory right to appeal, 42 CFR 413.24 explains the procedures and timelines for submission of cost reports. Paragraph (f) states in part:

> Amended cost reports to revise cost report information that have been previously submitted by providers may be permitted or required as determined by CMS.

The Provider Reimbursement Manual (PRM) §2931.2A provides additional guidance regarding when amended cost reports may be permitted, or required, stating that:

> Ordinarily, a cost report filed in a manner consistent with regulations and policy governing its preparation is intended to be the final when settlement is made or following an audit when determined to be necessary by the Intermediary. However, a cost report may also be considered final when initially delivered to the intermediary, although the intermediary may not have performed its desk review and if necessary its audit.
>
> Under limited circumstances, the program will accept an amended cost report. An amended cost report is one which is intended to revise information submitted on a cost report which has been previously filed by the provider.

[2] See also 42 CFR 405.1835 and 405.1841.

> A provider may file or an intermediary may require an amended cost report to:
>
> 1. correct material errors detected subsequent to the filing of the original cost report,
>
> 2. comply with the health insurance policies or regulations, or
>
> 3. reflect a settlement of a contested liability....

The acceptance of, or refusal to accept, an amended cost report is at the discretion of the Intermediary. In addition, certain other procedures not contemplated by the statute are set forth in the regulation. The regulation at 42 CFR 405.1885(a) allows for a reopening of a determination or an NPR if "made within 3 years of the date of the notice of the intermediary determination." However, the regulation at 42 CFR 405.1885(c) provides that:

> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

The right to appeal a revised NPR that is the result of a reopening is strictly a limited regulatory right under 42 CFR 405.1889.

In this case, the Provider filed its cost report on November 30, 2000 and did not claim certain emergency room availability costs.[3] On July 8, 2002, the Provider requested to include these costs in its cost report for fiscal year ending June 30, 2000[4] The Provider submitted a request to reopen the FYE 2000 cost report, by letter dated February 11, 2003. The FYE June 30, 2000 NPR was subsequently dated April 30, 2003.[5] On May 9, 2003, the Intermediary denied the Provider's request to reopen the FYE 2000 cost report.[6]

The Administrator finds that the Provider appealed the emergency room availability costs pursuant to the FYE June 30, 2000 NPR. The Provider never claimed these costs on the NPR and hence cannot demonstrate "dissatisfaction" as required for Board jurisdiction except for the narrow circumstances presented in Bethesada Hospital v. Bowen, 485 U.S. 399 (1988). The Provider alleged that it was appealing the Intermediary's refusal to "change its cost report." However, the

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[3] Intermediary's Final Position Paper, Page No. 5..
[4] Intermediary Exhibit I-1.
[5] Intermediary Exhibit I-3.
[6] Intermediary Exhibit I-4.

"intermediary's final determination" in this case is represented by the FYE 2000 NPR. In contrast, the Intermediary's action with respect to the Provider's attempt to amend its cost report prior to the issuance of the NPR is not a final determination within the meaning of §1878 of the Act. The meaning of final determination does not encompass the situation in which the Intermediary refuses to act on a request to amend a cost report prior to the issuance of an NPR. Moreover, as the Intermediary was not required to accept the amended cost report, or request to amend, no argument can be made that this NPR reflects a final determination on that Provider request. Thus, the Intermediary action with respect to refusing to allow the Provider to amend the cost report is not subject to Board review. In addition, as the Supreme Court has found in Your Home Visiting Nursing Services v. Secretary, 119 S. Ct. 930 (1999), the Intermediary's denial of the Provider's request to reopen the FYE 2000 cost report is not a final determination subject to Board review.

However, the issue remains whether the Provider was required to claim the costs on the cost report and show dissatisfaction for the Board to have jurisdiction over this issue. That is, would the regulations have precluded the Intermediary from granting the Provider the relief it now requests making such a claim futile and Board jurisdiction proper under a Bethesda analysis.

The Provider's characterized of the issue as involving documentation for emergency room physician availability costs[7] would at first glance lead one to conclude that the Provider was required to claim these costs on the cost report in order to preserve a Board appeal. However, the issue in fact involves compensation cost for physician assistants under Part A.[8] Both the statute and

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[7] See, e.g., Provider's October 26, 2003 letter requesting a Board hearing "of the Medicare intermediary due to the denial of including physician provider hours and costs in the cost reports."; Intermediary Exhibit I-1, Provider letter dated July 8, 2002 stating that provider "was eligible for additional emergency room physician reimbursement...."

[8] The Board erroneously states that the Intermediary withdrew the issue of whether physician assistant compensation could be paid under the physician compensation regulation and manual. The transcript shows that the Intermediary did not withdraw that issue. Rather, the Intermediary raised multiple grounds for disallowing these costs (see Intermediary Position Paper, pp-6-17), including documentation and jurisdiction. That is, it appeared the Intermediary was arguing that even if one assumed, *arguendo*, these costs could be evaluate under section 2109 of the Manual, the Provider failed to meet that criteria. In addition, if one assumes, *arguendo*, that the Provider costs could be evaluated under that criteria, than the Provider also needed to have claimed the costs on the cost report to preserve Board jurisdiction.

regulation refers to physicians and physician assistants as distinct and separate practitioner.[9] The regulation at 42 CFR 415.60 sets forth specific documentation requirements for providers to be paid Part A reimbursement for "physician" services to providers. Further, the Provider Reimbursement Manual at section 2109 sets forth the specific documentation requirement to be paid for emergency room physician availability compensation. Both the regulation and Manual refers to "physician" services or compensation, not to physician assistant services or compensation. Because the compensation at issue is for physician assistants, not physician compensation, the Intermediary can not make Part A payment under 42 CFR 415.60 and Section 2109, et seq., of the Manual for these costs. As the Provider failed to claim these costs on its cost report, the Board's jurisdiction can only be found because the Intermediary had no authority to grant the Provider the requested relief for reimbursement as a Part A physician service under 42 CFR 415.60 or section 2109 of the Manual.

Instead, the regulation at 42 CFR 410.74 explains that Medicare Part B covers "physician assistant" services only if the following conditions are met:

> (1) The services would be covered as physicians' services if furnished by a physician (a doctor of medicine or osteopathy, as set forth in section 1861(r)(1) of the Act).
> (2) The physician assistant --
> (i) Meets the qualifications set forth in paragraph (c) of this section;
> (ii) Is legally authorized to perform the services in the State in which they are performed;
> (iii) Performs services that are not otherwise precluded from coverage because of a statutory exclusion;
> (iv) Performs the services under the general supervision of a physician. (The supervising physician need not be physically present when the physician assistant is performing the services unless required by State law; however, the supervising physician must be immediately available to the physician assistant for consultation.);
> (v) Furnishes services that are billed by the employer of a physician assistant; and
> (vi) Performs the services –

[9] See Section 1861r of the Act defining "physician"; Section 1861q of the Act defining "physician services"; Section 1861aa(5)(A) of the Act defining "physician assistant."

(A) In all settings in either rural and urban areas; or
(B) As an assistant at surgery.

A physician assistant must also meet certain qualifications for Medicare Part B coverage of his or her services. The regulation at 42 CFR 410.74 does not provide for payment of Part A physician assistant emergency room availability costs, such as those claimed in this case.[10] Thus, the Board was correct in finding that these costs were not allowed, however, the reason the costs are not allowed is that for the cost year and provider at issue, the law does not allow reimbursement for physician assistant "availability" costs under Part A.[11] The Administrator finds that these services, to the extent they are payable under Medicare for this Provider and cost year, can only be paid by a carrier in accordance with 42 CFR 410.74.[12]

[10] See also Change Request: 3228; Transmittal: 285 (dated August 27, 2004)(Intermediary Exhibit I-8). The Medicare Modernization Act of 2003 (Pub. Law 108-173) established new changes for Critical Access Hospitals (CAH). CAHs may include, inter alia, physical assistants in computing reasonable compensation and related costs for emergency room on-call coverage effective for dates of service on, or after, January 1, 2005. The payment maybe made via the cost report settlement process. However, the provider in this case was not a CAH for the cost reporting period at issue and the cost year at issue is prior to this change in the law. The required change is evidence that these costs were not allowed prior to the effective date of January 1, 2005 through the cost reporting process.

[11] In the alternative, the Administrator agrees that the Provider did not meet the criteria for payment under section 2109 of the Manual and 42 CFR 415.60, as not only did the costs not involve physicians, but the Provider did not have, *inter alia*, the required written allocation agreement.

[12] The record in fact shows that the Provider did bill and receive Part B payment for these services.

DECISION

The Administrator affirms the Board consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 2/16/07 /s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services