PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D54

PROVIDER -St. Joseph Hospital
North Providence, Rhode Island

DATE OF HEARING-
February 4, 1998

Provider Nos. 41-0005 & 41-5005

vs.

Cost Reporting Period Ended -
September 30, 1988

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Rhode Island

CASE NO. 91-1799

INDEX

Page No.

Issue **2**

Statement of the Case and Procedural History **2**

Provider's Contentions **3**

Intermediary's Contentions **5**

Citation of Law, Regulations & Program Instructions **8**

Findings of Fact, Conclusions of Law and Discussion **10**

Decision and Order **10**

ISSUE:

Was the Intermediary correct in applying reasonable compensation equivalent calculations to physicians who are employees of the management firm with which the hospital contracted to provide administrative services in the hospital's exempt psychiatric unit?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Joseph Hospital, ("Provider") is a hospital located in North Providence, Rhode Island. On February 10, 1986, the Provider entered into an agreement with Mental Health Management, Inc. ("MHM") to staff and manage the Provider's 28 bed psychiatric unit.[1] This Management Agreement was revised on August 22, 1986, to reflect the state of Rhode Island's Certificate of Need approval for the Provider to operate only a 20 bed inpatient psychiatric unit.[2] Among MHM's duties were to provide a clinical director, associate clinical director, program manager, two psychiatric social workers, one psychologist with a doctor of philosophy, and an activities therapist. In return for providing this staffing, MHM received a composite rate $68 per patient day.[3]

In a separate agreement dated November 14, 1986 (amended on March 1, 1987), MHM contracted with Dr. Capone to serve as Clinical Director.[4] In another agreement dated November 17, 1986 (amended on April 1, 1987 and April 12, 1988), MHM contracted with Dr. Beltran to serve as the Associate Clinical Director.[5] During the fiscal year ended September 30, 1988 ("FY 88") MHM paid Drs. Capone and Beltran $85,000 and $56,000 respectively, for services under these agreements.

Under the agreements both physicians directly billed for their physician services. Thus, their entire compensation from MHM was for physician administrative services. The Provider filed its FY 88 Medicare cost report without reflecting the compensation of these two physicians on Worksheet A-8-2. On audit, the Intermediary requested that the Provider supply documentation of the compensation these physicians received for time spent on administrative duties at the Provider's exempt bed psychiatric unit.[6] No data was received

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1 See Provider Exhibit G.

2 See Provider Exhibit H.

3 See Provider Exhibit B.

4 See Provider Exhibits I and J.

5 See Provider Exhibits K, L, and M.

6 See Intermediary Exhibit 7.

from the Provider to determine and substantiate the physicians' salaries. However, the Provider did subsequently supply HCFA Forms 339 for the two physicians.[7] The Intermediary reviewed the contracts between MHM and these two physicians and included their compensation on Worksheet A-8-2 as indicated within their contracts.[8] The physicians' hours at the Provider were also included on Worksheet A-8-2. These hours reflected a prorated balance for the total year.[9] 845 hours were allowed for Dr. Capone and 600 hours for Dr. Beltran. In total, this equals the 1,445 hours as adjusted in #178D.[10] In addition to the above adjustments, the Intermediary also applied the reasonable compensation equivalent ("RCE") as specified in Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub 15-1"), § 2182.6 to the two physicians' psychiatry specialty compensation. These adjustments resulted in a disallowance of $81,672 and reduction in Medicare reimbursement of approximately $47,000.

The Provider appealed these adjustments to the Provider Reimbursement Review Board ("Board"). The filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.
The Provider was represented by Thomas Crane, Esquire, of Hickley, Allen and Snyder. The Intermediary was represented by Michael F. Berkey, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the hospital's expenses paid to MHM for its costs in providing physician services are fully allowable purchased management and administrative support services. The governing Medicare program rules for the Provider's expenditures to MHM is HCFA Pub. 15-1 §§ 2135.1-2135.4. It makes no distinction as to the type of purchased management and administrative support services covered under its scope. On its face it clearly applies to all of the services provided by MHM, including the services of Drs. Capone and Beltran.

The Provider notes that the Intermediary has not challenged the Provider's costs under this provision of the Provider Reimbursement Manual. The reasons are obvious. There is a demonstrable need for this service as certified by the Provider's Certificate of Need from the

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7 See Intermediary Exhibit 8.

8 See audit adjustments 178A + 178B at Intermediary Exhibit 2.

9 See Intermediary Exhibit 8.

10 See Intermediary Exhibit 2.

state.[11] The Provider conducted a full-scale feasibility study.[12] It weighed the desirability of providing the service through an outside management company.[13] It sought bids from three unrelated companies and selected the lowest cost supplier.[14] This process clearly should lead to a presumption of reasonableness of the expenditures in question under HCFA Pub. 15-1 PRM
§ 2135.

The Provider observes that given the proper diligence that it demonstrated in selecting MHM and assuring that the total costs of the agreement were reasonable, the Intermediary may not now select out certain components, such as the services of the above two physicians and attack the costs of those services. PRM § 2135.3 states:

> [i]f certain individual services are more expensive than could be purchased elsewhere, the reasonable cost of these components will not be disallowed if the cost of the aggregate services is not substantially out of line with a comparable package of services available in the marketplace.

HCFA Pub. 15-1 § 2135.3. (Emphasis added)

The Provider further argues that the Intermediary improperly applied the RCE limits to the services of Drs. Capone and Beltran paid by MHM. The Intermediary side-tracks the central issue when its relies on 42 C.F.R. § 405.481 for the first time, stating that this "specific" provision should override the broad manual provision discussed above.[15] The Intermediary asserts in essence that the RCE rules apply when a physician is compensated by a provider either directly or indirectly. For good reason, the Intermediary would like the Board to believe that the governing rule is 42 C.F.R. § 405.481. This allocation rule clearly applies to physician compensation costs paid directly by a provider, by a related party, or "under arrangements". The problem is, however, that this section has no relevance to the issue before the Board because the agreements with Drs. Capone and Beltran do not cover physician services, and the allocation between physician services and administrative services of a physician is not in dispute. Consequently, this inapplicable regulation cannot override the clearly applicable manual provision HCFA Pub. 15-1
§ 2135.

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11 See Provider Exhibits A.

12 Id.

13 See Provider Exhibits E and F.

14 See Provider Exhibits B, C, D, and G.

15 The Intermediary originally relied on 42 C.F.R. § 413.24.

The Provider argues that the real issue before the Board is whether the Intermediary may apply the RCE limits of 42 C.F.R. § 405.482 and HCFA Pub. 15-1 § 2182.6 to the facts of this case. By its plain meaning, however, these provisions are inapplicable. In clear contrast to 42 C.F.R.
§ 405.481, which applies to services under arrangement, 42 C.F.R. § 405.482 avoids the term physician compensation costs and applies only to compensation paid to physicians by providers. The rationale for this longer reach of the allocation rule rather than the RCE limits is obvious. Section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), settled a long-standing dispute over the reimbursement treatment of services of a physician to providers by making clear in a new § 1887 that such services are to be covered under Medicare Part A and are to be paid for on a reasonable cost basis. Such services are fundamentally distinguishable from physician services paid for under Medicare Part B on a usual, customary, and reasonable charge basis. HCFA could not implement this fundamental requirement unless allocations were made for all services of a physician whether paid for by a provider, related party, or independent third party under arrangement with the provider. If HCFA's allocation rule did not reach all physician services it would clearly have frustrated congressional intent. Thus, a far reaching allocation rule was necessary.

The Provider further argues that once the proper allocation is made thus assuring the appropriate source of payments, the question becomes whether the costs in question are reasonable. Here the question of the applicability of the RCE limits must be considered. Unlike the allocation rule however, HCFA realized that it need not extend the scope of the RCE limits to situations where the provider was not directly paying the physician. As discussed above, HCFA has fully protected the program from unreasonable contract services. Moreover, HCFA has recognized that it would be manifestly unfair to penalize a provider for contracting decisions made by a third party. HCFA Pub. 15-1 § 2135 makes clear that as long as the overall contract is reasonable, an Intermediary may not come in and pick certain services that it finds unreasonable. Even HCFA Pub. 15-1
§ 2182.6C also cautions that an intermediary must examine the inherent reasonableness of the arrangement. This approach makes eminent sense. The Provider is fully prepared to justify the overall reasonableness of its contract with MHM, but it is arbitrary for the Intermediary to challenge contractual decisions made between MHM and these two physicians. The regulatory scheme established by HCFA fully recognizes this unfairness in applying RCE limits to the services here and fully protects the program from unreasonable contract expenditures.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that:

(1) The services rendered by the physicians were Part A services. The contracts[16] for the

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[16] See Intermediary Exhibits 5 and 6.

clinical director states in pertinent part:

> (a) Establishing necessary parameters and guidelines for members of the Medical Staff who practice in the program regarding the psychiatric treatment of patients in the Psychiatric Program. Doctor shall supervise and evaluate the psychiatric treatment provided in the Psychiatric Program...
>
> (b) Assisting MHM in the development of Policies and Procedures specifying the scope and conduct of patient care rendered.
>
> (c) Participating in the Psychiatric Quality Assurance Program. . .
>
> (d) Providing clinical supervision to the non-medical professional staff. . .
>
> (e) Assisting in developing objectives and guidelines for in service educational programs. . .
>
> (f) Maintaining liaison with members of the Medical Staff of HOSPITAL. . .
>
> (g) Assisting. . . in minimizing controllable costs.
>
> (h) Assisting in the periodic review and revision of policies, procedures, rules and regulations of the Program.

The associate clinical director performs functions[17] similar to those of the clinical director above. Both contracts specify that none of the time spent by either doctor shall be construed as direct patient care services.

(2) 42 C.F.R. § 405.480 states in pertinent part:

> [c]osts a provider incurs for services of physicians are allowable only if the following conditions are met:
>
> > (1) The services do not meet the conditions. . . regarding reasonable charge reimbursement for services of physicians to an individual patient of a provider;
> >
> > (2) The services do not include physician availability services. . .
> >
> > (3) The provider has incurred a cost for salary . . .; and

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[17] See Intermediary Exhibit 6 for details.

> (4) The costs incurred by the provider for the services meet the requirements regarding costs related to patient care.

42 C.F.R. § 405.480.

(3) HCFA Pub. 15-1, § 2182.6 reinforces the above regulation. The following excerpt of the manual instructions explains that the physician services which are allowable for Part A reimbursement:

> [i]nclude, for example, departmental administration, supervision and training of staff, quality control activity. . .

HCFA Pub. 15-1 § 2182.6.

The Intermediary further argues that a physician does not have to receive compensation directly from a provider in order to be required to have this compensation reflected on Worksheet A-8-2 of the Medicare cost report. The clinical director and associate clinical director are required under their respective contracts to spend a minimum number of hours each week performing Part A duties for the Provider's psychiatric unit. These two physicians are compensated for their time spent performing these duties by MHM. All provider-based physician compensation for provider services are reimbursed on a reasonable cost basis, and no matter from what source, must be reflected on Worksheet A-8-2 and must be analyzed in relation to the proper RCE.

42 C.F.R. § 405.481 defines physician compensation costs, in pertinent part, as:

> [m]onetary payments, fringe benefits, deferred compensation and any other items of value. . . . a provider or other organization furnishes a physician in return for the physician's services. other organizations are entities related to the provider. . .or entities that furnish services for the provider "under arrangements" within the meaning of the act.

42 C.F.R. § 405.481. (Emphasis added.)

HCFA Pub 15-1, § 2182.3 defines physician compensation similarly. It also specifically explains that physician compensation must include any payment from an entity that furnishes services for the provider "under arrangements". This is precisely the situation in this appeal. The two physicians in question were reimbursed for their services to the Provider by MHM which provides services "under arrangements" to the psychiatric unit of the Provider.

The Intermediary notes that the RCE is the measure of physician compensation which is reimbursable under Medicare. 42 C.F.R. § 405.480 states in pertinent part:

> Limits on allowable costs. In determining its payments to a provider for the costs of services that meet the conditions for payment. . ., the intermediary must apply the limits on compensation set forth in [section] 405.482.

42 C.F.R. § 405.480.

42 C.F.R. § 405.482(a) states in pertinent part:

> HCFA will establish reasonable compensation equivalent (RCE) limits on the amount of compensation paid to physicians by providers. These limits will be applied to a provider's costs incurred in compensating physicians for services to the provider. . .

42 C.F.R. § 405.482(a).

42 C.F.R. § 405.482(c) goes on to explain the application of these limits:

> If the level of compensation exceeds the limits established. . . . Medicare payment will be based on the level established by the limits.

42 C.F.R. § 405.482(c).

HCFA Pub 15-1, § 2182.6C, states in pertinent part:

> The Intermediary uses the RCE levels to compute reimbursement when the physician is compensated by the provider or other related organization for administrative, supervisory, and other provider services that are reimbursable under Medicare.

HCFA Pub. 15-1 § 2182.6C.

The Intermediary observes that the Provider's citation of HCFA Pub 15-1 § 2135.3D.1 as authority to exempt these physicians from the reasonable compensation equivalent is inappropriate. This manual instruction explains the evaluation process necessary for services purchased. These services can either be componentized or not, depending on the other analyses available to determine reasonableness. The Provider has not explained their process whereby it has determined that the contract with MHM was the most feasible. In addition to the above paragraph, the regulations and manual instructions, as cited in earlier arguments, are specific in their treatment of physicians compensated by a provider, either directly or indirectly. Because of this the Intermediary contends that these regulations must govern. HCFA Pub. 15-1, § 2135, which discusses treatment of purchased services, would not be applicable in this case.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

2. Regulation - 42 C.F.R.:

§ 405.480	-	Payment for Services of Physicians to Providers: General Rules
§ 405.480(a)	-	Allowable Costs
§ 405.481	-	Allocation of Physician Compensation Costs
§ 405.482	-	Limits on Compensation for Services of Physicians in Providers
§ 405.482(a)	-	Principle and Scope
§ 405.482(c)	-	Application of Limits
§ 405.482(e)	-	Exception to Limits
§§ 405.1835-.1841	-	Board Jurisdiction

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2135.1	-	General
§ 2135.2	-	Evaluation of the Need for Purchased Management and Administrative Support Services
§ 2135.3	-	Determination of the Reasonable Cost of Purchased Management and Administrative Support Services
§ 2135.4	-	Factors to be Considered in Determining Reasonable Cost of Purchased Management and Administrative Support Services

§ 2182.3	-	Allocation of Physician Compensation
§ 2182.6	-	Conditions of Payment for Costs of Physicians' Services to Providers

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, evidence, and parties' contentions finds and concludes that the Intermediary properly applied 42 C.F.R. §§ 405.480 - .482 to the facts in this case. Thus, RCE limits were properly applied to the physician compensation paid by the Provider to MHM. The regulation at 42 C.F.R. § 405.482 limits the amount of compensation paid to physicians by providers. The limits are applied to the provider's costs incurred in compensating physicians for services to the Provider. The regulation at 42 C.F.R. § 405.480(a)(3) includes in provider costs "salary or other compensation." Physician compensation is further defined in 42 C.F.R. § 405.481 as monetary payments a provider or "other organization" furnishes a physician in return for the physician's services. The regulation describes other organizations as parties related to the provider within the meaning of 42 C.F.R.
§ 413.17, or entities that furnish services to the provider "under arrangements".

The facts in this case clearly meet the "under arrangement" requirement. The Provider contracted with MHM to provide physician administrative services and overview of the Provider's psychiatric unit. Thus, those costs meet the regulation definition of physician costs and are subject to the RCE limits. It could be argued that the "under arrangement" definition is included in the allocation regulation (42 C.F.R. § 405.481) and that since the Provider's contract was 100% administrative, no allocation was required and that the regulation does not apply. The Board does not accept this argument. Every contract for physician services needs to be analyzed and reviewed to determine what type of physician services are being performed, i.e., professional services or administrative services. Thus, in reviewing payments for those services, allocations must be made based on the facts, and the regulations at 42 C.F.R. §§ 405.480 and .481 should be applied to those facts. The reality that a specific contract only results in administrative costs does not change the application of regulations and negate the application of RCE limits.

The Board notes that the Provider did use good judgment in selecting a supplier and has demonstrated that it properly applied the prudent buyer concept. If the Provider had sought an exception to the RCE limit under 42 C.F.R. § 405.482(e) because it was unable to recruit or maintain an adequate number of physicians at a compensation level within the limits, it may have obtained relief from the limits. However, this was not done.

DECISION AND ORDER:

The RCE limits apply to the compensation paid by the Provider to MHM for physician administration services. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: May 21, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman