PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2000-D32

PROVIDER -
Methodist Hospital
St. Louis Park, Minn.

Provider No. 24-0053

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association
Blue Cross and Blue Shield of Minnesota

DATE OF HEARING-
October 15, 1999

Cost Reporting Period Ended -
December 31, 1994

CASE NO. 98-0448

INDEX

ISSUE:

Was the Intermediary's disallowance of the physician Part A compensation due to inadequate physician time studies proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist hospital ("Provider") is located in St. Louis Park, Minnesota. For the cost report period ended December 31, 1994, Blue Cross and Blue Shield of Minnesota ("Intermediary") disallowed the physicians' Part-A compensation due to its determination that there was a lack of documentation to substantiate the Provider's cost. The Provider's physician time records were completed and signed by the physicians on a monthly basis. There is no detail to support the monthly time records. The time records indicated that there was teaching and administrative duties performed by the physicians.[1] The Intermediary determined that the physician time studies were inadequate and allocated the physician compensation as 100% physician services to patients, thus removing physician compensation from allowable cost. This resulted in $471,352 of salary and 8,901 hours being reclassified as professional component on worksheet A-8-2, thus removing the physician compensation from Part A allowable cost.

The Provider disagreed with the Intermediary's determination and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.§§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount in contention is approximately $39,935.

The Provider was represented by William F. Telleen, Vice President and Chief financial Officer, Health Systems, Minnesota. The Intermediary was represented by Bernard M. Talbert Esq. of the Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that the time studies satisfy all of the requirements outlined in, 42 C.F.R. §405.481 and HCFA Pub. 15-1 §2182.3. The regulation at 42 C.F.R. §405.481 (f)(1)(i) and the HCFA Pub. 15-1 §2182.3(D)(1)(a), require a written agreement between a provider and the physician that specifies the respective amounts of time the physician spends furnishing services to the provider, the patient, and non-reimbursable services. The Provider argues that it is in compliance with these regulations. The Provider contends that its contracts with the hospital based-physicians prove that it is in compliance with the Medicare regulation and the HCFA manual.

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[1] See Exhibit P-5.

The Provider contends that the actual contract between it and one of its physicians, includes a clause stating that all services provided by the physician are Part A services. The Provider contends that this type of contract was used for all physicians, excluding the emergency room, laboratory and the artificial kidney unit. The contracts for those physicians also state that the compensation that is received from the Provider is for Part A services only.

The Provider points out that the regulation at 42 C.F.R.§ 405.481(g)(1) and HCFA Pub. 15-1 § 2182 et seq require that providers claiming payment for services of physicians maintain documentation to support the above allocation agreement. The document needs to be in a form that can be validated by the intermediary. HCFA Pub. 15-1 §2182.3(E)(1) references to §2182.13 for an example of a format that providers may use to substantiate allocation agreements. The time studies used by the Provider's hospital based physicians are modeled after the example at §2182.13.

The Provider contends that its time study is a copy of an actual time study by one of its doctors. The time study is in sufficient detail to document that the physician spent time supervising technicians and nurses, teaching, performing quality control, and performing administrative duties. The time studies for the emergency room and artificial kidney unit are also in sufficient detail to document that they are time spent supervising technicians and nurses, teaching, performing quality control, and performing administrative duties. The laboratory time studies were determined to be adequate by the Intermediary.

The Provider argues that the physician time study issue was appealed on its October 31, 1989 cost report. In that case the Board ruled in favor of the Provider, but the HCFA Administrator overturned the decision and ruled in favor of the Intermediary. Methodist Hospital, St. Louis Park, Minn. v. Blue Cross and Blue Shield Assoc./ Blue Cross and Blue Shield of Minn. PRRB Dec. No. 98-D6, Nov. 6, 1997, Medicare and Medicaid Guide ("CCH") §45,761, HCFA Adm. Dec. December 29, 1997 rev'd. Medicare and Medicaid Guide ("CCH") §46,051. ("Methodist") The Administrator's decision pointed out that the Provider failed to meet the requirements of 42 C.F.R. §405.481. The two requirements were: lack of a written allocation agreement between the Provider and the hospital based physicians and failure to maintain documentation to validate its allocation of physician services as Part A services. The Provider points out that the two issues that led to the HCFA Administrator's decision to overturn the Board's ruling have been corrected. Therefore, the HCFA Administrator's ruling on the October 31, 1989 cost report appeal should not be relied upon during the review of the December 31, 1994 appeal. The Provider argues that the allocation agreements between it and the hospital based physicians document that the hospital based physicians are providing only Part A services. The hospital based physicians Part A hours are substantiated through monthly time studies that were maintained in the format recommended by HCFA.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not meet the record keeping requirement as stated in 42 C.F.R. §405.481 which states:

> (g) Recordkeeping requirements; Except for services furnished in accordance with the assumed allocation under paragraph (e) of this

> section, each provider that claims payment for services of physicians under this subpart must:
>
> (1) Maintain the time records or other information it used to allocate physician compensation in a form that permits the information to be validated by the intermediary or carrier;

The Intermediary argues that the Provider's records were not adequately supported by actual auditable data accumulated by the Provider during the cost report period.[2] Monthly summaries of the provider-based physicians hours do not represent auditable data.

The Intermediary points out that Medicare Bulletin #193 (dated September 14, 1990) reaffirms policy and requirements for reimbursement of provider based physicians. The bulletin states:

> If no such agreement exists, the intermediary will assume that the physician's compensation is 100 percent physician services to patients.

The regulations also state the record keeping requirements in 42 C.F.R.§405.481 (g) to be the following:

> The provider must, "maintain time records or other information it used to allocate physician compensation."

The Intermediary points out that Medicare Bulletin # 196 (dated December 21, 1990) clarifies Medicare Bulletin #193 as to what are acceptable time records. It states:

> As the September 14, 1990 bulletin indicates, that provider must maintain verifiable time records or other information used to support the allocation of the physician compensation. This means,according to 42 C. F.R.§ 405.481, that verifiable time records must be available to support Part A hours and/or Part A/PartB time splits. Amounts reported in contracts or the HCFA-339 do not suffice as verifiable documentation. Verifiable support may take the form of either daily time reports maintained by the physician or time studies completed by the physician. If time studies are used, the time studies should, at a minimum, be performed two weeks each quarter.

The Intermediary contends that these bulletins are merely clarifications and affirmations of existing program policy. Detailed and auditable time records have always been required and thus the Provider does not meet the requirements under 42 C.F.R.§ 405.481. Therefore, the documentation is inadequate and the cost should be considered 100% Part B.

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[2] See Exhibit I-4.

The Intermediary points out that the HCFA Administrator's decision in Methodist pointed out that the Provider failed to meet several of the key requirements of 42 C.F.R. §405.481. The Provider's records were lacking written allocation agreements for the physicians that would designate the physician's time spent between Part A Part B, and non-Medicare services. This is expressly required by 42 C.F.R.§405.481 (f)(1)(i). The HCFA Administrator also points out that per 42 C.F.R.§ 405.481 (f)(2), that without an agreement, 100 percent of the physicians' compensation should be allocated to Part B services.

The Intermediary contends that in the Administrator's decision, the Provider did not maintain sufficient documentation to validate its allocation of the physician's services to Part A. The document entitled "Medicare Part A Time Report" that the physicians completed each month did not have a stated basis for the allocations reported (i.e., time studies, time reports). The Provider failed to provide daily time logs, or time studies for the physicians, which would support their position, except in the area of Pathology.

CITATION OF PROGRAM LAWS, REGULATIONS AND INSTRUCTIONS:

1. Regulations 42 C.F.R.:

§405.481 et seq.	-	Allocation of Physician Compensation Costs
§§405.1835-.1841	-	Boards Authority
§405.1867	-	Sources of Board's Authority

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

§2182 et seq.	-	Services of Physicians in Providers

4. Cases:

Methodist Hospital, St. Louis Park, Minn. v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Minnesota, PRRB Dec.No 98-D6, Nov. 6, 1997, Medicare and Medicaid Guide (“CCH”) §45,761, HCFA Adm. Dec. dated December 29, 1997, rev’d. Medicare and Medicaid Guide (“CCH”) §46,051.

5. Other:

Medicare Bulletin #193 September 14, 1990
Medicare Bulletin #196 December 21, 1990

HCFA Memorandum BPO F-12, February 1, 1990

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority after consideration of the facts, parties contentions, and evidence presented finds that the Provider did have contracts with the physicians which allocated the Physicians time. The Board majority also finds that there were monthly time studies prepared by the physicians which allocated their time.

The majority of the Board finds that there were contracts between the Provider and the physicians which allocated the physicians time to Part A services. This is in conformity with the regulations at 42 C.F.R. §405.481 (f)(l) which states:

> the intermediary will reimburse the provider for those costs only if (i) The provider submits to the intermediary a written allocation agreement between the provider and the physician that specifies the respective amounts of time the physician spends in furnishing physician services to the provider, physician services to patients, and services that are not reimbursable under either Part A or Part B of Medicare;....

Id.

Therefore, the majority of the Board finds that the Provider did have a signed written agreement with the physicians and was in compliance with the stated regulation.

The majority of the Board finds that the Provider maintained sufficient documentation to support the allocation agreement. The time study used by the Provider was in sufficient detail to document that the physician spent time supervising technicians and nurses, teaching, performing quality control, and performing administrative duties. Although the time study in evidence was for a one month period and lacked the actual daily detail, the majority of the Board finds that the physicians are the best final judge of the time they spend. The monthly summary is signed by the physician who attests to its accuracy. Therefore, the majority of the Board find that the monthly summary complies with the requirements of HCFA Pub. 15-1 §2182.3.

In an attempt to put the issue in this appeal in perspective, the Board Majority cites the Federal Register dealing with GME reaudits:

> It is important that the amount determined to be an accurate reflection of legitimate GME costs incurred during the Federal FY 1984 base period.

HCFA Memorandum BPO F-12 Feb. 1, 1990.

There is evidence in the record indicating the existence of an approved training program. There is also evidence indicating that the physicians supplied teaching and supervision to the residents. Additionally, the amount being claimed for these activities appears reasonable.

The majority of the Board notes that it did not give great weight to the Intermediary's contention that its Medicare Bulletin's #196 and #193 clarified the issue as to what constitutes acceptable time records. The majority of the Board finds that these Bulletins were prepared by the Intermediary; they are not Blue Cross/Blue Shield Association documents, nor are they HCFA documents. While Medicare Bulletin # 196 describes verifiable support as ... either daily time reports maintained by the physician or time studies completed by the physician..... HCFA Pub. 15-1 §2182.3(E)(4) states that "While we do not require the maintenance of daily logs or time records to support provider services rendered by physicians." Therefore, the majority of the Board finds that the evidence presented by the Provider is adequate.

The majority of the Board finds that there was evidence of an allocation Between Part A and Part B physician cost, and, therefore, the Intermediary's adjustment was improper.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the physicians Part A compensation was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover Jr., Esq.
Charles R. Barker (dissenting opinion)

Date of Decision: March 23, 2000

For the Board:

Irvin W. Kues
Chairman

Dissenting Opinion of Charles R. Barker

I respectfully dissent.

I view this case as one to be decided based on the documentation supporting the allocation of physician compensation.

In summary, 42 C.F.R. §405.481(f) requires that the Provider have a written allocation agreement designating the Physicians time between Part A, Part B and non-Medicare services. In addition, it requires that the Provider maintain sufficient documentation (time records or other information) that can be validated by the Intermediary to support the time allocations.

These two points are noted in the Administrator's reversal of PRRB Decision 98-D6 for the Provider on the same issue. The Provider's position paper states that, "the two issues that lead to the Administrator's decision to overturn the board's ruling have been corrected." With regard to the availability of written allocation agreements, we would agree with the Provider. The second issue related to documentation is at best the same and possibly has deteriorated.

The majority of the Board views the Provider's documentation (Medicare Part A Time Reports) as sufficient supporting documentation, I find them to be deficient as follows:

1) The time report is not a time study but rather a monthly summary of how the physicians believe they spent their time.

2) The source or basis of the information in the time report is not identified as well as the reports in evidence were not dated.

3) The Intermediary's audit work papers state that there was "no other documentation available" that they could use to validate the time reports.

4) The Provider had full knowledge of the record keeping requirements in the regulations and instructions through Medicare Bulletins #193 and 196. It can be argued that the interpretative guidance offered by the Intermediary may be somewhat inflexible, however the Provider was aware of the reviewing criteria for several years. They therefore could have complied with the minimum amount of information necessary for validation.

5) There appears to be no misunderstanding of the record keeping requirement (time records or other information) as the Provider/Physicians did maintain acceptable time studies (one per quarter) for several of the physicians in the Pathology Department.

With all due respect to the Physicians as being the parties to best know how they spend their time, the documented record (Medicare Part A Time Report) is only a monthly summary report of how the physicians believe they spent their time which is not capable of being validated by any identified source data.

While the adjustment may seem somewhat harsh in that the Part A Physician cost and hours are totally reclassified to Part B (Professional) services, and therefore causing a reduction in reimbursement for the Provider, the Provider was totally in control of the situation, in that they were knowingly capable of providing verifiable documentation. As a result there is no other apparent remedy for the situation. I will sustain the adjustments made by the Intermediary to the Provider.

Charles R. Barker Date