CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Marias Medical Center	
Provider	**Determination for Cost Reporting Period Ending: June 30, 2004**
vs.	
Blue Cross BlueShield Association	**Review of:** **PRRB Dec. No. 2008-D40** **Dated: September 29, 2008**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. CMS' Center for Medicare Management (CMM) also submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Provider is a 20 bed, Critical Access Hospital (CAH) located in Shelby, Montana. The Provider contracted with a Certified Registered Nurse Anesthesiologist (CRNA) to provide non-physician anesthesiology services under an arrangement as an independent contractor. The contract contained a provision that the Provider would pay standby costs to the CRNA.

The Provider included these CRNA standby costs on its cost report for fiscal year ending (FYE) June 30, 2004. The Intermediary audited the cost reports and denied reimbursement of the standby costs, resulting in a reduction of Medicare reimbursement of approximately $16,328.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary properly denied reimbursement of the CRNA standby costs. The Board found that the Intermediary's disallowance of the standby costs was improper. The Board stated that there is no evidence that it was ever "longstanding" CMS policy to disallow standby costs and that 42 C.F.R. §412.113(c) states that the reimbursement of CRNAs is paid on a reasonable cost basis. The standby costs at issue in this case are reasonable because they would be reimbursed similarly to other hospital staff.

SUMMARY OF COMMENTS

The Intermediary submitted comments and asserted that the regulation for a CAH only permits stand-by costs for physicians, physician assistants, nurse practitioners and clinical nurse specialists. The Intermediary argued that stand-by time is not permitted as a reasonable cost for a CRNA.

CMM submitted comments requesting that the Board's decision be reversed. CMM stated that the Board improperly allowed the stand-by costs associated with the CRNA.

The Provider commented, requesting affirmation of the Board's decision. The Provider claimed that the CMM's argument that the Board erred in confusing the term "standby" with availability and on call services is overly broad and an incorrect statement. The Provider asserted Medicare makes no such distinction and that the citations provided by CMM do not apply in this instance.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered.

Prior to 1983, Medicare primarily reimbursed providers on a reasonable cost basis. Section 1861(v)(1)(a) of the Act defines "reasonable cost" as "the cost actually incurred, excluding there from any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." Section 1861(v)(1)(a) of the Act does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The Secretary promulgated regulations which explained the principle that reimbursement to providers must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.[1] Reasonable cost includes all necessary and proper cost incurred in furnishing the services. Necessary and proper costs are costs, which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Accordingly, if a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the Program, those costs will not be paid by the Medicare program.

In addition to the reasonable cost principles outlined in 42 C.F.R. §413.9 of the regulation, the regulation at 42 C.F.R. §413.70 provides that providers designated as Critical Access Hospitals will be paid reasonable cost for inpatient services furnished to Medicare beneficiaries. Both sections of regulation apply in determining reasonable cost for the Provider in this case, however, neither section of the regulation identifies CRNA "standby" costs as a reasonable cost.

The statute, regulations and program instructions do not contemplate that normal standby costs are considered reasonable costs. The Board erred in confusing the term "standby" with availability and on call services. Standby costs are not equivalent to on call costs for Medicare purposes. For Medicare purposes, "standby" does not include and is not used interchangeably with physician availability or on call services. This principle is reflected in the statute at Section 1861(v)(1)(A) of the Act which states the following within the context of establishing implementing regulations on this issue:

> Such regulations shall (i) take into account both direct and indirect costs of providers of services (<u>excluding there from any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs</u>

[1] <u>See</u> e.g. 42 C.F.R. §413.9.

> established under this title) in order that, under the methods of determining costs, the necessary cost of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and …" (Emphasis added.)

The regulation at 42 C.F.R. §413.9 states that reasonable costs include "normal standby" costs, which indicates that only some standby costs would be allowable. While the term "normal standby" cost is not defined in the regulations, the Provider Reimbursement Manual (PRM) includes several examples of situations in which standby costs are allowable. Section 2102.1 of the PRM indicates that standby costs are defined as those attributable to unoccupied beds (depreciation, operation of plant, etc.). In addition, the PRM at §2342 states:

> Where the unoccupied beds in a partially certified institution are concentrated in the certified portion, the standby costs attributable to the unoccupied beds (e.g., depreciation, operation of plant, etc.)…"

The "standby" costs specifically included by statute are related to the provider's physical plant or structure and not related to the personnel staffing the hospital. In contrast, costs for "availability" of personnel and costs for personnel to be on call are only allowable as defined in PRM §2109 and 42 C.F.R. §413.70(b)(4).

The CRNA costs included in the provider's cost report as "standby cost" are not a cost of services provided and are not allowable as either "availability" costs or as "on call" costs. PRM §2109.2 defines "availability" as the physical presence of a physician in a hospital. PRM §2109.1 states:

> Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section.

The allowance of these costs in emergency rooms was intended for the specific purpose of assuring physician availability in that setting. The costs for availability of personnel other than physicians (such as CRNAs) are not allowable in the emergency room or anywhere else in the hospital.

On call costs are allowable only as described in 42 C.F.R. 413.70(b)(4) which states:

> 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 physician's services, and is not on call at any other provider or facility.

Effective January 1, 2005, the reasonable costs of a CAH's outpatient services also can include amounts for reasonable compensation of emergency room physician assistants, nurse practitioners, and clinical nurse specialists who are on call off-site, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility.[2] The on call costs for a CAH are recognized only for the CAH's emergency room, and only as described in that section of the regulation. The cost for any other on call personnel not specified in the regulations is not an allowable cost.

In light of the foregoing, the Administrator finds that the Board's decision was improper. The standby costs claimed by the Provider in this case are not attributable to unoccupied beds (depreciation, operation of plant), the physical presence of a physician in the CAH's emergency room, nor the costs for approved non-physician specialists in a CAH's emergency room after January 1, 2005. Accordingly, the Administrator reverses the Board's decision in this case.

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[2] See, 42 C.F.R. 413.70(b)(4).

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed.

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

Date: __**11/21/08**_________ _**/s/**_____________________________

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