PROVIDER REIMBURSEMENT REVIEW BOARD

2024-D24

PROVIDERS –
VA Behavioral Health CYs 2016 & 2017
Disallowance of Professional Costs CIRP Group

HEARING DATE –
April 26, 2023

PROVIDER NOS. –
49-4010
49-4021

CALENDAR YEARS –
2016
2017

vs.

MEDICARE CONTRACTOR –
Palmetto GBA
c/o National Government Services, Inc. (J-M)

CASE NO. –
21-0266GC

INDEX

Page No.

Issue Statement **2**

Decision **2**

Introduction **2**

Statement of Facts and Relevant Law **2**

Discussion, Findings of Facts, and Conclusions of Law **13**

Decision **18**

ISSUE STATEMENT:

Whether the Medicare Contractor's decision to disallow all professional costs for the Providers' fiscal years ("FYs") 2016 and 2017 was proper, given the Providers are teaching hospitals?[1]

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds the Medicare Contractor properly disallowed the Providers' professional costs at issue for the fiscal years ("FYs") 2016 and 2017.

INTRODUCTION:

This common issue related party ("CIRP") group consists of two public psychiatric hospitals operated by the Commonwealth of Virginia Department of Behavioral Health and Developmental Services (collectively the "VA Behavioral Health Hospitals") and the two periods at issue are the Providers' FYs 2016 and 2017 which each end June 30th. Specifically, the VA Behavioral Health Hospitals are the following psychiatric hospitals: (1) Western State Hospital ("Western State"); and (2) Northern Virginia Mental Health Institute ("NVMHI").[2] The Medicare Contractor[3] assigned to the VA Behavioral Health Providers is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").[4]

Each of the VA Behavioral Health Providers appealed their respective cost reports for FYs 2016 and 2017,[5] and are challenging audit adjustments made by the Medicare Contractor which disallowed all costs for direct care physician services rendered to patients ("professional costs").[6] Both VA Behavioral Health Providers timely requested a hearing before the Board and met the jurisdictional requirements for an appeal. Accordingly, the Board held a live video hearing on April 26, 2023. The VA Behavioral Health Providers were represented by Jonathan Joseph, Esq. of Christian & Barton, LLP. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS AND RELEVANT LAW:

For hospital cost reporting periods beginning on or after July 1, 1985, the Medicare program began paying teaching hospitals for the costs of residents' compensation (representing payment

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[1] This is the issue agreed to by the parties. Transcript ("Tr.") at 6.
[2] Tr. at 9. *See also* Providers' Final Position Paper (hereinafter "Providers' FPP") at 4-5 (Jan. 26, 2023).
[3] CMS's 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 and relevant.
[4] Providers' FPP at 4.
[5] The VA Behavioral Health Providers' appeal for CY 2017 was originally in Case No. 21-1145GC. In a letter dated April 13, 2021, the Board agreed to consolidate the CY 2017 appeal into Case No. 21-0266GC (the CY 2016 appeal).
[6] Providers' FPP at 4.

for the residents' services), certain physician compensation costs related to GME programs, and other GME program costs based on hospital-specific per-resident amounts as described in 42 C.F.R. § 413.86, in accordance with 42 U.S.C. § 1395ww(h). Physician compensation costs for administrative and supervisory services unrelated to the GME program or other approved educational activities are payable as operating costs through diagnosis related group payments under the prospective payment system for inpatient services and on a reasonable cost basis for inpatient services in hospitals excluded from the prospective payment system and for outpatient services. In the case of those few teaching hospitals that elect reasonable cost payments for physician direct medical and surgical services under 42 U.S.C. § 1395x(b)(7) instead of billing for services to Medicare beneficiaries on a fee-for-service basis, the election and payment mechanisms are described at 42 C.F.R. §§ 415.160, 415.162, and 415.164.[7] Specifically, 42 U.S.C. § 1395x(b) states in relevant part:

> (b)INPATIENT HOSPITAL SERVICES. The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital— . . .
>
> (6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association . . . ; or
>
> (7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this subchapter for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this subchapter.

Pursuant to the provisions of 42 C.F.R. §415.160 payment for physician services furnished to Medicare beneficiaries in a teaching hospital setting are covered under Medicare Part B *except those teaching hospitals that have elected cost reimbursement*.[8] A hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians *in lieu of* any payment on a reasonable charge or fee schedule basis that might otherwise be payable for those services ***if*** the hospital has an approved teaching program, the hospital submits an election request in writing to the Medicare Contractor, and meets the other specific conditions of 42 C.F.R § 415.160(b).

Title 42, Part 415, Subpart D[9] governs payment for physician services provided in teaching hospital settings. It defines the terms "teaching hospital," "teaching physician," and "teaching setting" in 42 C.F.R. § 415.152 as follows:

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[7] 60 Fed. Reg. 63178, 63181 (Dec. 8, 1995); 77 Fed. Reg. 29028 (May 16, 2012).
[8] Prior to December 8, 1995, this regulation was located at 42 C.F.R § 405.521. 60 Fed. Reg. 63124, 63136, 63142 (Dec. 8, 1995).
[9] *See also* 42 C.F.R. § 415.150.

> *Teaching hospital* means a hospital **engaged in an approved GME residency program** in medicine, osteopathy, dentistry, or podiatry.
>
> *Teaching physician* means a physician (other than another resident) **who involves residents in the care of his or her patients**.
>
> *Teaching setting* means any provider, hospital-based provider, or nonprovider settings **in which Medicare payment for the services of residents is made under the direct GME payment provisions of §§413.75 through 413.83**, or on a reasonable-cost basis under the provisions of §409.26 or §409.40(f) for resident services furnished in skilled nursing facilities or home health agencies, respectively.[10]

Thus, in order to be a teaching hospital during a fiscal year, the hospital must be "engaged in an approved GME residency program." The definition of "teaching setting" suggests that being "engaged in an approved GME residency program" is more than just actually having residents but also receiving "Medicare payment for the services of residents . . . under the direct GME payment provisions."

The scope of Title 42, Part 415, Subpart D is set forth in 42 C.F.R. § 415.150 and it specifies that payments to teaching hospitals are made through one of three payment methods:

> This subpart sets forth the rules governing payment for the services of physicians in teaching settings and the criteria for determining whether the payments are made as one of the following:
>
> (a) Services to the hospital under the reasonable cost election in §§ 415.160 through 415.164.
>
> (b) Provider services through the direct GME payment mechanism in §§ 413.75 through 413.83 of this chapter.
>
> (c) Physician services to beneficiaries under the physician fee schedule as set forth in part 414 of this chapter.

A hospital is paid for professional costs on a fee schedule basis pursuant to 42 C.F.R. § 415.160(d) unless it is a teaching hospital and an election is made to be paid on a reasonable cost basis pursuant to 42 C.F.R. § 415.160(a) which states:

> (a) *Scope*. A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments that might otherwise be made for these services.

[10] (Italics in original and bold and underline emphasis added.)

The conditions that a teaching hospital must meet in order to be paid on a reasonable cost basis for physician services are contained at 42 C.F.R. § 415.160(b) which states:

> (b) *Conditions*. A teaching hospital may elect to receive these payments only if—
>
> (1) The hospital notifies its intermediary in writing of the election and meets the conditions of either paragraph (b)(2) or paragraph (b)(3) of this section;
>
> (2) All physicians who furnish services to Medicare beneficiaries in the hospital agree not to bill charges for these services; or
>
> (3) All physicians who furnish services to Medicare beneficiaries in the hospital are employees of the hospital and, as a condition of employment, are precluded from billing for these services.
>
> (c) *Effect of election*. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to beneficiaries—
>
> (1) Those services and the supervision of interns and residents furnishing care to individual beneficiaries are covered as hospital services, and
>
> (2) The intermediary pays the hospital for those services on a reasonable cost basis under the rules in § 415.162. (Payment for other physician compensation costs related to approved GME programs is made as described in § 413.78 of this chapter.)
>
> (d) *Election declined*. If the teaching hospital does not make this election, payment is made—
>
> (1) For physician services furnished to beneficiaries on a fee schedule basis as described in part 414 subject to the rules in this subpart, and
>
> (2) For the supervision of interns and residents as described in §§ 413.75 through 413.83.

Once a teaching hospital makes the election to be paid on a reasonable cost basis for professional costs, the payment rules at 42 C.F.R. § 415.162(b) apply, which state:

> (b) *Reasonable cost of physician services and supervision of interns and residents*. (1) Physician services furnished to beneficiaries and supervision of interns and residents furnishing care to beneficiaries in a teaching hospital are payable as provider services on a reasonable-cost basis.

> (2) For purposes of this paragraph, reasonable cost is defined as the direct salary paid to these physicians, plus applicable fringe benefits.
>
> (3) The costs must be allocated to the services as provided by paragraph (j) of this section and apportioned to program beneficiaries as provided by paragraph (g) of this section.
>
> (4) Other allowable costs incurred by the provider related to the services described in this paragraph are payable subject to the requirements applicable to all other provider services.

A hospital that elects to be paid on a reasonable cost basis for direct care physician services *must* allocate physician compensation to the range of services provided, and this allocation *must* be capable of substantiation, as stated in 42 C.F.R. § 415.162(j):

> (j) *Allocation of compensation paid to physicians in a teaching hospital*. (1) In determining reasonable cost under this section, the compensation paid by a teaching hospital, or a medical school or related organization under arrangement with the hospital, to physicians in a teaching hospital must be allocated to the full range of services implicit in the physician compensation arrangements. (However, see paragraph (d) of this section for the computation of the "salary equivalent" payments for volunteer services furnished to patients.)
>
> (2) This allocation must be made and must be capable of substantiation on the basis of the proportion of each physician's time spent in furnishing each type of service to the hospital or medical school.

The Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2182 addresses the services of physicians in providers for services performed on or after October 1, 1983. In particular, PRM 15-1 § 2182.3 provides additional guidance regarding the allocation of physician compensation and states in Subsection (B) that these costs must be allocated "in proportion to the percentage of total time" spent in furnishing: 1) physician services to the provider; 2) physician services to patients; and 3) non-reimbursable physician activities. PRM 15-1 § 2182.3(E) provides "Recordkeeping Requirements" and specifies in Paragraph (1) that "[w]hile providers have some discretion with regards to the types of records they maintain as to the allocation of physicians' time to services, the allocations ***must*** be supported by adequate documentation and *must* normally be comparable to previous allocations or to similar situations in comparable providers."[11] Specifically, providers ***must*** meet the following recordkeeping requirements to support their allocations:

- Maintain the data and information used to allocate physician compensation *in a form that permits validation* by the intermediary and the carrier;

[11] (Emphasis added.)

> - Report the data or information on which the physician compensation allocation is based to the intermediary and promptly *notify the intermediary of **any revisions** to the compensation allocation*; and
>
> - Retain each physician compensation allocation agreement, and the information on which it is based, for at least 4 years after the end of each cost reporting period to which the allocation applies.[12]

Finally, PRM 15-1 § 2182.3(E)(3) specifies that "[a]llocation agreements are to be submitted annually as part of the cost report filing process."

The Medicare Contractor states it disallowed all professional costs "due to a lack of documentation to support the allocations of time spent."[13] Providers are required to "maintain sufficient financial records and statistical data for proper determination of costs payable under the [Medicare] program."[14] Specific recordkeeping requirements are outlined at 42 C.F.R. § 413.20(d)(1) and (2) which state:

> (1) The provider must furnish such information to the contractor as may be necessary to—
>
> (i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;
>
> (ii) Receive program payments; and
>
> (iii) Satisfy program overpayment determinations.
>
> (2) The provider must permit the contractor to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due…

The Medicare Contractor further questions whether the VA Behavioral Health Hospitals met the conditions to make an election, including submitting a proper election request to the Medicare Contractor.[15]

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[12] PRM 15-1, Section 2182.3(E)(2).
[13] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") (Feb. 23, 2023) at 3.
[14] 42 C.F.R. § 413.20(a).
[15] Medicare Contractor's FPP at 7; *id*. at 7 n.3 (stating: "The Providers do not have full time equivalent caps or a GME per resident amount reported on its cost reports and do not claim or receive reimbursement for GME or Indirect Medical Education (IME) costs. No documentation was supplied to substantiate that residents did in fact rotate to the disputed hospitals during the disputed fiscal years."); *id.* at 8 (stating: "for NVMHI, no documentation, such as physician contracts, affiliation agreements or hospital bi-laws, privileges, etc., was provided to support that the physicians agree not to bill charges for their services."); Medicare Contractor's Preliminary Position Paper (Oct. 21, 2021) at 7 (stating: "The MAC contends that while the

The VA Behavioral Health Hospitals maintain that: (1) they each were teaching hospitals;[16] (2) they each made the election to be paid on a reasonable cost basis;[17] and (3) they should be paid as teaching hospitals for the reasonable cost of their physicians' professional services pursuant to 42 C.F.R. § 415.162 and PRM 15-1 § 2148.[18] The VA Behavioral Health Hospitals argue that the Medicare Contractor improperly applied 42 C.F.R. § 415.60 and PRM 15-1 § 2182.3(E) when it made audit adjustments for FYs 2016 and 2017, and that the Medicare Contractor did not understand the reimbursement sought was for physician services rendered directly to hospital patients.[19] The VA Behavioral Health Hospitals claim that they have exceeded documentation requirements under the proper standard, and the substantiating documentation includes "monthly time studies completed by the treating physicians" which allocated the time spent providing each different type of service.[20]

As an alternative argument, the VA Behavioral Health Hospitals request that, if the Board finds their professional costs documentation is insufficient, the Board follow the approach it took in its 2012 decision for the *Lemuel Shattuck* case.[21] In the *Lemuel Shattuck* case, the provider sought reimbursement for professional costs on a reasonable cost basis, and challenged the methodology used by the Medicare Contractor to allocate these costs between Medicare Part A and Medicare Part B. Specifically, the Board found the Medicare Contractor's methodology used to adjust professional costs for Part B services that lacked acceptable times studies was flawed. The Board ordered the Medicare Contractor "to apply the average allowable Part B percentages of teaching hospitals in Massachusetts for that same cost reporting period" for each of the cost reporting periods at issue in the case.[22]

One of the VA Behavioral Health Hospitals, Western State, previously operated as a general acute care hospital under Provider No. 49-0106 and converted to a free-standing psychiatric hospital under Provider No. 49-4021 effective on October 1, 2014.[23] Western State argues the fact that "the [Medicare Contractor] has no record of an election" after it transition to a free-standing psychiatric facility is "irrelevant because cost-based reimbursement is a standalone

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providers may be affiliated with other programs and act as participating sites to other providers program(s), it has not been documented that they are in fact teaching hospitals. Neither provider has claimed or received indirect or graduate medical education (IME/GME) payments for its intern and resident expenses for the FYEs at issue. Neither provider has submitted affiliation agreements that detail their relationship with the sponsoring institutions, as applicable. Neither hospital has a full-time equivalent (FTE) cap or a per-resident amount (PRA) reported on their cost report for the FYEs at issue. Without an FTE cap and a PRA, the Provider cannot receive GME reimbursement. Reference **Exhibit C-7**. Finally, neither hospital has had its FTE's audited for propriety by the MAC, as the providers have not claimed reimbursement related to their interns and residents."); *id.* at 7 (stating: "the MAC has no documentation to show that the election was ever made for either provider); *id*. (stating: "No documentation was provided to support that the physicians agree not to bill charges for their services. Further, it is unclear if the physicians are employees of the hospitals or contracted.").

[16] Providers' FPP at 4, 7.

[17] *See* Tr. at 10. *See also* Providers' Post Hearing Brief (June 26, 2023) (hereinafter, "Providers' PHB") at 3.

[18] Providers' FPP at 5, 7.

[19] *Id.*

[20] *Id.*

[21] *Lemuel Shattuck Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. 2012-D22 (Aug. 10, 2012), *declined review*, CMS Adm'r (Sept. 25, 2012).

[22] *Id.* at 10.

[23] Providers' FPP at 5, n.3.

issue and it should "be reimbursed the same way regardless of whether it was an IPPS Hospital or a freestanding psychiatric facility."[24]

The VA Behavioral Health Hospitals also contend the "election by each facility to be reimbursed on the cost report for direct care services by Providers is noted on each Provider's cost report for each fiscal year at issue."[25] Specifically, they contend that "worksheet S-2, line 58 of the cost report asks the Provider *if they elect* reimbursement under PRM Section 2148 for the cost reimbursement of its physicians and it answered 'Yes'. So therefore, the MAC could concede that an election was made through the cost report because the regulations are not specific to say that you have to do it every year, you have to do it outside of the cost report, it just has to be in writing; so, we could concede that the answer to S-2 may be an election."[26] In support of their position, the VA Behavioral Health Hospitals cite to the Board's 2005 decision in *Trenton Psychiatric Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. 2006-D03 (Nov. 17, 2005) ("*Trenton*"), *vacating and remanding*, Adm'r Dec. (Jan. 18, 2006) and contend that, in this decision, the Board "makes clear that if a provider seeks cost-based reimbursement for its physician services on its cost report that qualifies as an election (which the Providers clearly did for the years under appeal)."[27]

The VA Behavioral Health Hospitals contend that they had year-round residents, and each resident was present for either 1.2 months (Western State) or 2 months (NVMHI) but did not introduce any testimony or evidence in support of this contention.[28] Indeed, notwithstanding the fact that they claim to be teaching hospitals, the VA Behavioral Health Hospitals are *not* seeking reimbursement for Graduate Medical Education ("GME") costs for FYs 2016 and 2017. As a result, they assert that they "do not need to report full time equivalent caps or a GME per resident amount [] on their cost reports."[29] The VA Behavioral Health Hospitals assert that the only review of hospital teaching credentialing that needs to be done is "verification that the program[s have] been approved by the applicable accrediting body."[30]

The VA Behavioral Health Hospitals contend the Medicare Contractor has acknowledged it cited to the wrong regulation during audit.[31] The VA Behavioral Health Hospitals assert that their physicians were not permitted to bill the relevant Medicare carrier under Medicare Part B.[32] The VA Behavioral Health Providers further claim that PRM 15-1 § 2148.5(B) required the Medicare Contractor to verify that Medicare Part B was not billed directly by the physicians but that it failed to ask them for that physician billing documentation.[33]

The VA Behavioral Health Hospitals explain the method of substantiation (the documentation) utilized for allocation was different between the two participants in this appeal. Specifically, they

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[24] Providers' Reply to Medicare Contractor's Final Position Paper (Mar. 23, 2023) (hereinafter "Providers' Reply Brief") at 4.
[25] *See* Tr. at 10.
[26] *Id.* at 110 (emphasis added).
[27] Providers' PHB at 3, n.2.
[28] Providers' Reply Brief at 5-6.
[29] *Id.* at 6.
[30] *Id.*
[31] Tr. at 25. *See also* Exhibits P-3, P-4, P-13 and P-14.
[32] Tr. 182-183. *See also* Providers' PHB at 3. Note that, in support of this assertion, each of the VA Behavioral Health Hospitals filed an affidavit from a medical director; however, they ***withdrew*** those affidavits from the record and dropped those medical directors from their witness list. Tr. at 7.
[33] Providers' PHB at 3, n.3 (citing to PRM 15-1 § 2148.5(B)).

claim that: (1) Western State physicians "submitted monthly e-mails with their allocation of time which was used to report allocations of physician time for cost reporting purposes";[34] and (2) NVMHI physicians "reported monthly allocations of their time to the Medical Director…who signed off on them."[35] For NVMHI, they did ***not*** enter into the record any of the actual monthly documents purportedly submitted by the NVMHI physicians for FYs 2016 and 2017, but rather entered into the record summaries for FY 2016 and 2017 of the purported hours reported by the Western State physicians where the only categories of time indicated for FY 2016 were "certified unit" and "admin. time" and then, significantly, an additional category of "forensic unit" was added to the mix.[36] Also, on the annual summary for FY 2016, the summary asserts that "15%" of all the total hours are teaching hours but does not explain how that "15%" was determined. There is no similar annual summary or teaching hour assertion for FY 2017. In contrast, Western State had semi-annual emails from its physicians that generally reported monthly break outs of time for each of the 6 months for the following categories: "Direct [Care]," "Teaching," and "Administrative." However, not all physicians submitted the email and in some cases the physicians did not report for all months.[37]

The VA Behavior Health Hospitals maintain that the Medicare Contractor's finding that there were zero hours of professional services rendered by its physicians in unreasonable because: (1) the correct regulation governing this case is 42 C.F.R. § 415.162; and (2) under this regulation, the allocation substantiation requirement was met in good faith.[38] The Providers add that the Medicare Contractor admitted at hearing that "the Provider's physicians clearly provided medical services to Medicare beneficiaries," and the amended cost reports "were not accurate in terms of reflecting the hours spent by the Providers' physicians."[39] The VA Behavioral Health Hospitals are asking the Board to find that the audit adjustments which disallowed all professional services were improper, and requests that the Board direct that the adjustments be reversed, or that an approach similar to that in Board's 2012 decision for the *Lemuel Shattuck* case be utilized.[40]

The Medicare Contractor's position is that the VA Behavioral Health Hospitals have not met the requirements of 42 C.F.R. § 415.160, the first being that the Providers must be teaching hospitals. Rather, these Hospitals only appear to be "participating sites" in other hospital's teaching programs.[41] The Medicare Contractor argues the second requirement of 42 C.F.R. § 415.160 is that the provider must "submit a written election to the MAC specifically stating that it elects cost reimbursement for its physician's professional services."[42] The Medicare Contractor notes that, while both facilities filed a written election for cost reimbursement in 1997, the Medicare Contractor denied those election in 1999 (more than 15 years prior to the fiscal years at issue). Further, the Medicare Contractor recognizes that Western State submitted another request in 2007 when it was participating in the Medicare program as an IPPS hospital, but notes that it "has no record of an election for [Western State] after [Western State] transitioned from an IPPS Hospital

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[34] *Id.* at 4.
[35] *Id.*
[36] The summaries of the NVMHI time studies for FYs 2016 and 2017 are located at Exhibits P-15 and P-16, respectively.
[37] The summaries of the Western State time studies for FYs 2016 and 2017 are located at Exhibits P-5 and P-6, respectively.
[38] Providers' PHB at 4.
[39] *Id. See also* Tr. at 45.
[40] Providers' PHB at 6.
[41] Medicare Contractor's FPP at 6 -7.
[42] *Id.* at 7.

to a freestanding psychiatric facility, which was effective 10/1/2014."[43] Similarly, the Medicare Contractor notes that it could not find any later written election for NVMHI and that NVMHI has not supplied any additional correspondence regarding such an election.[44]

Lastly, the Medicare Contractor asserts that all physicians furnishing services to Medicare beneficiaries in the hospital must "agree not to bill charges" for their service or "are employees of the hospital and as a condition of employment are precluded from billing for those services."[45] The Medicare Contractor states no such documentation stating physicians agree not to bill charges for their services was provided for NVMHI.[46] There is, however, evidence that Western State elected cost reimbursement, and that Western State's physicians agreed not to bill for services provided, as Western State's affiliation agreement (in effect for FY 2016) with the University of Virginia states "Third party billing: All physicians who furnish services at WSH agree not to bill any third party payors directly/indirectly for services provided at WSH."[47] Further, the Contractor notes that Western State "supplied attestations with the physicians' work profiles stating that each physician agrees not to bill."[48]

The Medicare Contractor also argues VA Behavioral Health Hospitals have not met the requirements of 42 C.F.R. § 415.162(j) to substantiate allocation of the professional costs "on the basis of the proportion of each physician's time spent in furnishing each type of service to the hospital…"[49] The Medicare Contractor claims the time studies submitted by the VA Behavioral Health Hospitals during audit "do not present a true representation of time spent and are not time studies."[50] Rather, they are *estimates* made by the physicians which do not contain documentation to substantiate the percentages and allocations reported.[51] As examples of appropriate supporting documentation the Medicare Contractor cited "physician contracts, physician allocation agreements, time sheets, paystubs, payroll exports, etc."[52]

The Medicare Contractor questions the information submitted by NVMHI during the FY 2016 audit, alleging there is no documentation or explanation to support the *post-hoc* across-the-board 15 percent teaching hours calculation applied to the annual summary.[53] Similarly, the Medicare Contactor questions the use of an 8 hour day by NVMHI in ***all*** of its physician remuneration calculations given that the hospital was "open 24 hours per day, 7 days a week."[54] The Medicare Contractor adds that NVMHI "did not submit documentation during audit to support that the remuneration reported on Worksheet A-8-2 [of the cost report] is only applicable to the salaried 8 hours/weekday."[55] The Medicare Contractor further notes that the physician work profiles provided by NVMHI "do not itemize salary or standard working hours."[56]

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[43] *Id.* at 7, n.4.
[44] *Id.* at 7.
[45] *Id.* at 8.
[46] Medicare Contractor's FPP at 8.
[47] *Id*.
[48] *Id.*
[49] *Id.* at 9.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id. See also* Exhibit C-10.
[54] Medicare Contractor's FPP at 10.
[55] *Id.*
[56] *Id.*

During the FY 2016 audit, Western State provided the Medicare Contractor with documentation to support its calculation of teaching percentages applied to total hours worked.[57] The Medicare Contractor explains that the Provider's supporting documentation calculates teaching percentages by using physician time attestation emails[58] to create "a yearly average percentage for each physician."[59] The Medicare Contractor explains the Provider's allocation method as "[e]ach physician's yearly average is then summed and averaged again to create an overall yearly average, which is then applied to the total hours worked, to calculate the amount of hours to allocate to the teaching component."[60] The Medicare Contractor argues that the Provider's use of "a series of estimates for its allocations that cannot be substantiated during audit . . . violates 42 C.F.R. §§ 415.162(b)(3) [and] (j)."[61]

The Medicare Contractor distinguishes this appeal from the *Shattuck* case by stating that it has not used an alternate allocation in this appeal as was done in *Shattuck.*[62] The Medicare Contractor offers that this appeal is similar to *Wilmington Treatment Center v. Palmetto GBA*, PRRB Dec. 2015-D21 (Sept. 3, 2015) ("*Wilmington*") in that the Providers have "not supplied sufficient documentation to allocate the amount of time that its physicians spent treating patients vs. providing services to the hospital vs. in non-allowable activities."[63] In the *Wilmington* decision, the Board found for the Medicare Contractor. Additionally, the Medicare Contractor contends the Providers cannot argue on one hand that the Medicare Contractor improperly relied upon 42 C.F.R. § 415.60 and PRM 15-1 § 2182(E) derived from the regulation, because they do not apply to them because they are teaching hospitals who are seeking cost-based reimbursement for professional services, which are excluded from following the allocation of physician compensation costs regulation and instructions. While on the other hand, they are seeking to use a nationwide average similar to the Board's application in the *Lemuel Shattuck* case which was based on a related PRM 15-1 instruction.[64]

Finally, the Medicare Contractor questions whether the VA Behavioral Health Hospitals met the conditions to make an election under 42 C.F.R. § 415.160(b)(1) for FYs 2016 and 2017, raising questions about whether: (1) they each submitted a proper election in writing to the Medicare Contractor; (2) they were teaching hospitals; or (3) their physicians were precluded as a condition of employment from billing for their professional services or had agreed not to bill for the professional services to the Medicare program.[65] The Medicare Contractor asserts that, even if the Providers are permitted to elect payment on a reasonable cost basis, neither Provider in this appeal made a valid election as there is no evidence of a written notification in the record and that this election must be made separate from the cost report.[66]

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[57] *Id. See also* Exhibit C-11.
[58] *See* Exhibit P-5.
[59] Medicare Contractor's FPP at 10.
[60] *Id.* at 11.
[61] *Id.*
[62] *Id.* at 12.
[63] *Id.* at 13.
[64] *Id.*; Medicare Contractor's FPP at 3.
[65] *See supra* note 15. At the hearing, the Medicare Contractor again questioned whether the hospital was a teaching hospital or had a teaching setting. Tr. at 175-76; Medicare Contractor's Post Hearing Brief (June 26, 2023) (hereinafter "Medicare Contractor's PHB") at 3-4. Notwithstanding, the Medicare Contractor recognizes that both Western State and NVMHI are each "listed as a participating site of an Accreditation Counsel for Graduate Medical Education residency program and is therefore a teaching hospital." Medicare Contractor's FPP at 4.
[66] Medicare Contractor's FPP at 5-6.

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW:

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds, as described below, that the Medicare Contractor's decision to disallow all professional costs was proper.

A. The VA Behavioral Health Hospitals failed to maintain contemporaneous documentation to properly support/substantiate the allocation of physician compensation.

This case primarily centers around whether the documentation to support the allocation of physician compensation to the range of services provided was adequate (as required by PRM 15-1, § 2182.3(B)) and capable of substantiation (as required by 42 C.F.R. § 415.162(j)). As part of the adequate documentation requirement, providers must "[m]aintain the data and information used to allocate physician compensation in a form that permits validation by the intermediary and the carrier."[67] This documentation should be contemporaneous, consistent with 42 C.F.R. §§ 413.20(a)[68] and 415.162.

The Board has reviewed the documentation in the record supporting the VA Behavioral Health Hospitals' allocation of their respective professional costs which, in their own words, consist of quarterly "average percentages for allocation of time for direct care and administrative activities."[69] The documentation generally identified only two categories of service -- Direct Care and Administrative; however, in some limited circumstances, it identifies Teaching as a category. Further, the documentation provides a number of hours/percentage of time spent by the physician in the named category, which is accumulated into a quarterly average. There is no other documentation addressing other categories such as research or non-allowable time such as time in a hospital unit not certified under the Medicare program.[70] Further, the underlying support for the hours reported on the NVMHI time studies is not available to verify the hour estimations.[71] In the cases where percentages of time spent are reported for Western State, there

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[67] PRM 15-1 § 2182.3(E).

[68] *See Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 793 (9th Cir. 2003); *Mercy Gen. Hosp. v. Azar*, 410 F. Supp. 3d 63, 80 (D.D.C. 2019); *Maine Med. Ctr. v. Burwell*, 775 F.3d 470, 482 (1st Cir. 2015).

[69] Exhibit P-5. *See also* Exhibits P-6, P-15, P-16.

[70] For example, the HCFA letter dated June 21, 1999 at Exhibit C-7 at C-0038 (emphasis added) provided the following guidance to the VA Behavioral Health Hospitals:

> Also, as I explained in my letter dated January 25, 1999, payment to these hospitals under the "cost election" is limited to the reasonable cost for Medicare patients treated *in the [Medicare] certified portion of the facility*. Therefore, the facility must be able to properly identify Medicare inpatient days and outpatient visit days for those services rendered ***only*** *in the [Medicare] certified areas of the facility*.

[71] For example, the FY 2017 NVMHI records at Exhibit P-16 were attested by the NVHMI Medical Director but that attestation is not dated. As a result, it is unclear when the purported attestations were made and whether those attestations were made contemporaneous with the relevant month. In this respect, there is no policy from NVMHI to document its procedure and process for creating those business records. In contrast, for FY 2016, the NVMHI records at Exhibit P-15 were not signed by the NVHMI Medical Director and there is no indication on the document as to when they were created. Finally, neither the NVHMI Medical Director nor the cost report preparer were present at the hearing and, as such, the Board was unable to clarify the issues and concerns related to these documents. As such, the Board declines to give Exhibits P-15 and P-16 any evidentiary weight. The Board has similar concerns and issues with the Western State records at Exhibits P-5 and P-6. For example, the quarterly summaries do not always reconcile with supporting emails received from each relevant physician, the reported time does not always add up to 100 percent, there are months included in the summary for which there is no supporting documentation from the physician, and the emails from the physicians were often not contemporaneous (*e.g.*, some emails covered July

are no underlying hours to support the percentages; and, thus, it is impossible to verify those percentages. Finally, there is no support/documentation or direct testimony to confirm whether each of the physicians worked an 8-hour day.[72] Accordingly, the documentation furnished is not auditable or verifiable and the Board agrees with the Medicare Contractor that there is not enough data and information to validate the allocation of total hours worked for these physicians or to verify the allocation between professional and provider components.[73,74]

Finally, the Board finds that the circumstances of the Board's 2012 decision in *Lemuel Shattuck* are materially different from those in this case and declines to apply it to this case. In *Lemuel Shattuck*, it was undisputed that the provider met the conditions to make an election and that the provider had some valid time studies for 30 percent of its physicians. To this end, the parties' dispute in *Lemuel Shattuck* was whether the provider was entitled to ***additional*** cost reimbursement under the allocation of the physician costs between Part A and Part B. Finally, the provider in the *Lemuel Shattuck* case was a general acute care hospital and there were multiple similarly situated hospitals in the same state as the provider (*i.e.,* in Massachusetts). Here, the Medicare Contractor disputes whether the VA Behavioral Health Hospitals met the conditions for an election (as discussed below in Subsection B) and did not allow any cost reimbursement based on its finding that there were not valid time studies or other auditable supporting documentation. Indeed, as discussed above, the Board agrees with the Medicare Contractor and rejects that documentation. Finally, unlike *Lemuel Shattuck*, there are no similarly-situated psychiatric hospitals in Virginia and, instead, the VA Behavioral Health Hospitals proposed to use 5 other psychiatric hospitals from across the nation. Further, the VA Behavioral Health Hospitals have not presented evidence to confirm how many actual residents it had during FYs 2016 and 2017 and, as such, it is not possible for the Board to assess whether these other psychiatric hospitals could be comparable.[75] Accordingly, the Board declines to give

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through November 2015 but were not sent until February 2016). Similarly, there was no witness presented at the hearing that could authenticate these documents or address these concerns and issues. As a result, the Board declines to give any weight to Exhibits P-5 and P-6. The Board recognizes that the VA Behavioral Health Hospitals had one witness at the hearing but the Board declines to give any weight to that testimony (particularly as it relates to Exhibits P-5, P-6, P-15 and P-16) since this witness had no personal knowledge of the Hospitals' operations, was not employed at either Hospital, and was not involved in the preparation of the cost reports at issue. Tr. at 151-52, 194-95.

[72] Tr. at 76-77, 161, 188-89.

[73] For example at Exhibit C-10 at 1, the Medicare Contractor's notes for NVMHI's physician hours summary for FY 2016 state: "Hours agree to MCR. No auditable documentation to verify actual hours worked and verification of the allocation of professional and provider."

[74] In making this finding, the Board recognizes that, in NVMHI's reconsideration request to the Medicare Contractor for FYs 2016 and 2017, NVMHI also made the argument that "[i]t is our belief that the documentation provided is sufficient based on 42 CFR 415.60(e) (f). This regulation [at 415.60(f)(2)] states that if there is no written allocation agreement between the physician and the provider, all costs would be assigned to professional time." Exhibits P-19, P-20. However, in parsing through § 415.60, it is clear that, by its terms,§ 415.60(f)(2) does not apply to teaching hospitals that have made election to be paid on a reasonable cost basis in lieu of payments under the physician fee schedule. Specifically,§ 415.60(f)(2) applies only to services defined in subsection (b)(2) which in tum is defined as physician services to patients as described in§ 415.l 02, and§ 415.102 is limited to "fee schedule payment for physician services to beneficiaries," *i.e.,* payment *under the physician fee schedule*. Further, the discussion in the preamble to the rulemaking published at 48 Fed. Reg. 8902, 8911 (Mar. 2, 1983) discusses the purpose for § 415.60(f)(2) and confirms that the Provider's interpretation would be contrary to that purpose.

[75] For example, it is unclear whether the number of residents or residents per physician is comparable between the VA Behavioral Health Hospitals and the 5 hospitals in Exhibit P-9 (2 in Colorado, 2 in Missouri and 1 in Wisconsin). Tr. at 171-73. Without this information, it is unclear whether the 5 hospitals have similar or comparable portions of their time spent on teaching. Similarly, the differences between the 5 hospitals between FYs 2016 and 2017 further suggests that the data itself is not reliable/comparable. For example, the Colorado Mental

the purported comparable hospitals any evidentiary value and finds that the approach used in *Lemuel Shattuck* is not applicable here.

In summary, the VA Behavior Health Hospitals failed to meet "its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [they are] entitled to relief on the merits of the matter at issue" as explained at 42 C.F.R. § 405.1871(a)(3).[76]

B. It is unclear whether the VA Behavioral Health Hospitals met the conditions for an election under 42 C.F.R. § 415.160(b)(1) to be paid on a reasonable cost basis for physician professional services.

The Medicare Contractor raised questions about whether each of the VA Behavioral Health Hospitals met the conditions to claim the election on their as-filed cost reports for FYs 2016 and 2017.[77] First, the parties dispute whether or not each of the VA Behavioral Health Hospitals properly submitted written notification to the Medicare Contractor that they were making an election for payment of professional services on a reasonable cost basis for FYs 2016 and 2017. This written notification is required by 42 C.F.R. § 415.160(b)(1). The Medicare Contractor has provided copy of a letter received on July 9, 1997, in which both Providers made an election to be paid on a reasonable cost basis for professional services.[78] At that time, Western State was an IPPS hospital which has since, effective October 1, 2014, participated in the Medicare program as a Psychiatric Hospital under a different provider number.[79] There is also documentary evidence that, effective July 1, 1999, the Medicare Contractor revoked the VA Behavioral Health Hospitals' election to be paid on a reasonable cost basis for professional services.[80] While there

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Health Institute in Pueblo had an allowable physician percentage of 94.24 percent for FY 2016 but this percentage was materially different for FY 2017 at 72.99 percent. Exhibit P-9 at P0155-56. Similarly, the Center for Behavioral Medicine in Missouri had an allowable physician percentage of 91.20 percent for FY 2016 but this percentage was materially different for FY 2017 at 68.13 percent. *Id.* Further, compounding these concerns is the fact that the as-filed cost reports for all 5 of the allegedly comparable hospitals for both FYs 2016 and 2017 were "settled without audit." *Id.* at P0157-72 (the middle column of the spreadsheet reads "Settled without Audit" for all 5 of these hospitals for both FYs 2016 and 2017); Tr. at 184-85.

[76] *See Lancaster Hosp. Corp v. Becerra*, 58 F.4th 124 (4th Cir. 2023) ("Lancaster asserts that—even if some reduction were warranted—the Board erred by denying its entire 1997 reimbursement request. There appears no doubt Lancaster provided services to Medicare beneficiaries in 1997 and denying all reimbursement for that year may seem harsh. But the principle that people 'must turn square corners when they deal with the Government' 'has its greatest force when a private party seeks to spend the Government's money.' *Heckler v. Community Health Servs. of Crawford Cnty., Inc.*, 467 U.S. 51, 63, 104 S.Ct. 2218, 81 L.Ed.2d 42 (1984). 'As a participant in the Medicare program,' Lancaster 'had a duty to familiarize itself with the legal requirements for cost reimbursement,' *id.* at 64, 104 S.Ct. 2218, including the need to provide cost data in a form 'capable of being audited,' 42 C.F.R. § 413.24(c). The Board's decision to deny reimbursement for fiscal year 1997 was neither arbitrary nor capricious and was supported by substantial evidence." (footnote omitted)).

[77] *See supra* note 15 and accompanying text.

[78] Exhibit C-7 at 1.

[79] *Id.*

[80] *Id.* at 2 (stating, in part: This is a follow-up to our meeting on May 19 . . . . As I indicated at this meeting that I could not approve State facilities to be reimbursed under the reasonable cost exception for physician services. . . . However, because of the length of time it took the Intermediary to resolve this issue and the fact that the exception request was initially approved, it is felt that a waiver should be granted for the fiscal years ended June 30, 1998 and June 30, 1999. . . . Also, as I explained in my letter dated January 25, 1999, payment to these hospitals under the 'cost election' is limited to the reasonable cost for Medicare patients treated in the certified portion of the facility. Therefore, the facility must be able to properly identify Medicare inpatient days and outpatient visit days for those services rendered only in the certified areas of the facility. As this waiver will end June 30, 1999, the State should

is an additional written request from Western State in the record dated October 9, 2007,[81] there is no record of any additional request made after October 1, 2014, when Western State terminated as an IPPS hospital and began operation under its new free-standing psychiatric hospital Provider Number, 49-4021. There is also no documentary evidence that NVMHI made any further request, in writing, to be paid on a reasonable cost basis since its 1997 request was denied in 1999. The Medicare Contractor has confirmed it was unable to locate, and the Provider has not supplied, any such correspondence.[82]

Further, the Board notes that the VA Behavioral Health Hospitals misconstrue the Board's 2006 decision in *Trenton* as there are material factual and legal distinctions. The provider in *Trenton* appealed its fiscal years ending June 30, 1996 through June 30, 1999 and had filed letters with the Medicare contractor earlier on December 19, 1991 and May 12, 1993. In this respect, the Board's decision in *Trenton* did not rely solely on the as-filed cost report form itself in determining whether the *Trenton* provider properly made an election. The Board agrees with the Medicare Contractor that, *at a minimum*, for FY 2016, the VA Behavioral Health Hospitals failed to properly notify the Medicare Contractor that they were electing to be paid on a reasonable cost basis for their physician professional services. While the Hospitals' prior history of filing election requests with the Medicare Contractor is not directly relevant given that they were 9+ years prior to the fiscal years at issue,[83] they do suggest that these Hospitals were aware that they needed to make their request outside the as-filed cost report. In this respect, the cost report instructions ask the following question in the past tense ("did you . . .") as opposed to present tense ("are you . . ."):

> As a teaching hospital, ***did*** *you elect* cost reimbursement for teaching physicians as defined in CMS Pub. 15-1, chapter 21, §2148? Enter "Y" for yes or "N" for no. If yes, complete Worksheet D-5.[84]

As a result, the cost report instructions are clear that a hospital should be making an election filing separate and apart from the cost report form itself and, *at a minimum*, the VA Behavioral Health Hospitals failed to make a proper election for FY 2016.[85]

Second, in order be paid on a reasonable cost basis for physician services, the VA Behavioral Health Hospitals were also required to demonstrate that all physicians agreed in writing not to bill charges for services to Medicare beneficiaries ***or*** that all physicians who were hospital

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undertake the steps necessary to begin billing the Medicare Part B carrier for the physician professional services effective July 1, 1999.").

[81] *Id.* at 3.

[82] Medicare Contractor's FPP at 7.

[83] Moreover, the 2007 request is not relevant as it pertained to a different provider agreement when Western State was participating in the Medicare program as an IPPS hospital as opposed to a psychiatric hospital. Outside of the 2007 request, the only request on record goes back more than 15 years to 1999. Hardly relevant to FYs 2016 and 2017.

[84] PRM 15-2, Ch. 40, § 4004.1, Line 58 (emphasis added).

[85] In this regard, the Board notes that the provider in *Trenton* was using a different cost report form (CMS-2552-96) which did not clearly make that distinction. This is another material difference. Notwithstanding, arguably, the as-filed could serve as notice of an election for the following year which in this case was FY 2017. The Board need not resolve that issue here as it is clear that other conditions to make the election have not been established.

employees, *as a condition of employment*, were precluded from billing for these services.[86] The Board notes that, while the Medicare Contractor stated that it did not ask for documentation concerning physician billing during the audit,[87] this does not relieve the VA Behavioral Health Hospitals of their responsibility to meet the conditions for payment on a reasonable cost basis contained in 42 C.F.R. § 415.160(b). In this respect, the Board notes that it has the authority to consider matters not considered in the original determination,[88] the Medicare Contractor raised this concern as an issue in this appeal, and VA Behavioral Health Hospitals were required to demonstrate that all of the physicians providing the professional services in dispute were either employees of the hospital that were precluded from billing for their services as a condition of employment, or had specifically agreed not to bill charges for their services.[89] The Board finds that, notwithstanding the Medicare Contactor raising the Hospitals compliance with the election conditions, there is no evidence in the record regarding these conditions for payment, whether documentation or testimony. Additionally, there is no documentary evidence of physician contracts or agreements not to bill.[90]

Finally, the Board notes that there are valid concerns whether each of the VA Behavioral Health Hospitals was a teaching hospital during FYs 2016 and 2017 given that neither hospital claimed any direct costs for their graduate medical education program on their FYs 2016 and 2017 as-filed cost reports and there is no evidence or direct testimony confirming residents were at these Hospitals during those fiscal years.[91]

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[86] 42 C.F.R. § 415.160(b).

[87] Tr. at 121, 122, and 182-183.

[88] *See* 42 U.S.C. § 1395oo(d) (stating: "A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. *The Board shall have the power to affirm,* ***modify****, or reverse a final determination* of the fiscal intermediary with respect to a cost report ***and*** *to make any other revisions on matters covered by such cost report (****including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination***." (emphasis added)); *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 405-06 (1988) (stating: "Section 1395oo (d), which sets forth the powers and duties of the Board once its jurisdiction has been invoked,3 explicitly provides that in making its decision whether to affirm, modify, or reverse the intermediary's decision, the Board can 'make any other revisions on matters covered by such cost report ... even though such matters were not considered by the intermediary in making such final determination.' This language allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation prescribed by Congress is that the matter must have been 'covered by such cost report,' that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.").

[89] 42 C.F.R. § 415.160(b)(2)-(3).

[90] The contract at Exhibit C-8 does not address this issue. Regardless, it is unclear whether any or all of the physicians at the VA Behavioral Health Hospitals for FYs 2016 and 2017 were even covered by this contract. Similarly, the VA Behavioral Health Hospitals *withdrew* the affidavits at Exhibits P-50 and P-51. Tr. at 7. *See also supra* note 71, *infra* note 91.

[91] The VA Behavioral Health Hospitals had filed witness lists on March 23, 2023 naming 2 medical directors as witnesses (one from NVMHI and one from Western State). On April 5, 2023, the Board denied a request to permit those 2 witnesses (plus another) from appearing via videoconferencing "because there is insufficient information in the record regarding the nature of the testimony for the Board to grant the request and the nature of the factual and legal disputes are complex." On April 19, 2023 (7 days prior to the hearing), they filed affidavits at Exhibits P-50 and P-51 from these 2 medical directors and then, on April 20, 2023, they filed an amended witness list *dropping* those 2 medical directors from the witness list. Then, the VA Behavioral Health Hospitals later *withdrew* Exhibits P-50 and P-51 from the record. Tr. at 7. As such, the Board did not consider them as part of this decision. Similarly, while the record does contain copies of affiliation agreements under which the VA Behavioral Health Hospitals each were affiliated with the GME program of another hospital, having an affiliation agreement does not mean that a hospital actually receives any residents during a particular fiscal year. In this regard, the Board notes

Thus, regardless of whether the VA Behavioral Health Hospitals had sufficient documentation to support the allocation of the costs of their physician professional services, the record before the Board does not establish that they each met the conditions for such an election under 42 C.F.R. § 415.160(b)(1) for FYs 2016 and 2017 consistent with the their obligations under 42 C.F.R. § 405.1871(a)(3). Rather, it supports a Board finding that they failed to meet one or more of those conditions.

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In summary, the Board finds the documentation to support allocation of physician compensation to the range of services provided was inadequate, and incapable of substantiation, as required by 42 C.F.R. § 415.162(j). While the basis for denial provided by the Medicare Contractor during the audit cited the incorrect regulation, the disallowance was proper because there is not enough documentary or testimonial evidence to support payment on a reasonable cost basis to the VA Behavioral Health Hospitals. Additionally, the Board finds that the VA Behavioral Health Hospitals have not established that they properly requested the payment exception in writing, nor did they provide evidence or testimony to establish that their physicians were employees of the hospitals that had agreed, in advance of the fiscal years at issue, to not bill the Medicare program for services provided to Medicare beneficiaries.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds the Medicare Contractor's decision to disallow all professional costs was proper, given the Providers are teaching hospitals.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

7/26/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

that the two (2) affiliation agreements entered into the record for NVMHI were not executed until near the end of FY 2016 and, as such, it is not clear NVMHI could have had any residents under those affiliation agreements during FY 2016. Finally, the definition of "teaching setting" suggests that being "engaged in an approved GME residency program" is more than just actually having residents but also claiming "Medicare payment for the services of residents . . . under the direct GME payment provisions." *See also supra* note 71.