PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D8

PROVIDER -
University Hospital of Syracuse
Syracuse, New York

Provider No. 33-0214

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

DATE OF HEARING-
May 9, 1997

CASE NO. 91-2866M

INDEX

ISSUE:

Were the Intermediary's adjustments to the graduate medical education ("GME") base year costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University Hospital of Syracuse ("Provider") is a non-profit teaching hospital located in Syracuse, New York. The Provider operated twenty one different medical services, each with GME components.[1] On February 28, 1991, Empire Blue Cross and Blue Shield ("Intermediary") issued a Notice of Average Per Resident Amount ("NAPRA") for payment of GME costs paid by Medicare on a prospective payment basis. The base year for determining prospective GME costs was the cost reporting period ended December 31, 1984.

During 1984, New York providers were reimbursed for services furnished to Medicare beneficiaries in accordance with the provisions of the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"), not Medicare's Prospective Payment System ("PPS"). Under NYPHRM providers were paid their Medicare operating costs subject to a fixed adjusted rate per day. That rate, in part, was based on a provider's average operating cost per day in a base year, updated annually by an inflation factor. The Provider's base year for computing its NYPHRM reimbursement for cost report years 1983, 1984 and 1985 was the cost reporting period ended December 31, 1981. These rates included GME costs.[2] Consequently, during the Medicare base year of 1984, the Provider did not have any consistent identification or segregation of GME versus non-GME costs for reporting or reimbursement because of the above waiver.

Since 1965, the Provider had obtained its pathology services, including inpatient services and teaching and other GME services, by contract with the Pathology Medical Service Group ("MSG").[3] Under that contract, MSG provided a variety of teaching and other services to the Provider despite no specific segregation in the 1965 contract of time devoted to GME versus time devoted to non-GME activities. Also, under the contract, the Provider billed Medicare for appropriate MSG services under the Medicare combined billing methodology until October 1983. It also paid MSG continuously for its professional and administrative services, including resident supervision and the administration of the residency program. After October 1983, the Provider began to negotiate a new contract with MSG because of the implementation of the Tax Equity and Fiscal Responsibility Act of 1982 which mandated the unbundling of physician services from hospital services. In the pathology department, only

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1 Transcript ("Tr.") at 143.

2 Tr. at 60.

3 See Provider Exhibit A-A.

"anatomical" services were billable to Medicare Part B as professional services provided directly by physicians. Thus, the Provider did not bill the teaching-related services under Part B and was also unable to recover for Part A pathology services including GME services in the per diem Medicare waiver NYPHRM rate.[4] The 1983 renegotiation of the MSG contract among other things, identified and segregated the true Part A Medicare costs, including those associated with GME.

The contract negotiation and approval process was not completed until 1988. In that year, the Provider sent a copy of the proposed new 1988 MSG contract[5] to the Intermediary. Attached to the proposed contract was an exhibit[6] which summarized the Part A hours per week worked by the Provider's pathologists in 1988, totaling approximately 8.88 full time equivalents ("FTEs"). The 8.88 FTEs included GME and administrative activities estimated at 6.38 FTEs and 2.50 FTEs, respectively. These FTEs was based on Reasonable Compensation Equivalents Limits and two-week time studies conducted by the Provider as part of its regular compliance with Intermediary and Health Care Financing Administration ("HCFA") directives. After the Provider sent the newly negotiated and proposed MSG contract to the Intermediary for its review in December 1988, the Intermediary returned the contract with comments on January 9, 1989. The Provider responded to these comments in March 1989 and finalized the new MSG contract in April 1989. On September 29, 1989, the final rules were issued for the reopening of the 1984 GME base year audit. Pursuant to 42 C.F.R. § 413.86(e)(1)(ii), the Intermediary in or about 1990 conducted an audit of the Provider's GME base period costs and reimbursement statistics in order to determine the Provider's base period average per resident amount ("APRA"). In August 1990, a three-week time study was designed and pre-approved by the Intermediary. This time study would indicate for all the Provider's 21 medical services the actual teaching physician hours worked that were dedicated to GME activities. For the pathologists, the results supported the 6.38 FTEs that had been previously identified for the 1988 MSG contract from a 1988 regular time study of the pathology department's Part A activities, including GME activities.

The Intermediary issued the Provider's NAPRA on February 28, 1991, based on total GME costs of $7,279,986 and 185.64 FTE interns and residents for an average per resident amount of $39,005.50.[7] On September 6, 1990, prior to the issuance of the NAPRA, the Provider requested that the Intermediary reclassify its pathology professional costs, which were misclassified by the Provider, for costs associated with teaching activities from operating expense to GME expense. The total laboratory professional components Part B elimination

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4 Tr. at 66.

5 Tr. at 74.

6 See Provider Exhibit A-G.

7 See Intermediary Exhibit 8.

on the Provider's 1984 submitted cost report, Worksheet A-8-2, was $1,676,747. The Provider requested that $1,257,560 of the Part B elimination be reclassified to Part A as follows: $1,006,050 to the supervising physician cost center and $251,510 to the pathology cost center. This results in 6.38 FTEs dedicated to pathology teaching activity. The Intermediary did not allow the additional FTEs to be included in the APRA determination. The Provider appealed this denial to the Provider Reimbursement Review Board ("Board"). The Provider's filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Mark Barnes, Esquire, of Proskaver, Rose LLP. The Intermediary was represented by Michael F. Berkey, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its pathology GME base year costs can and should be accurately reflected in the APRA calculation as equivalent to 6.38 FTEs for teaching physicians rather than the 1.94 FTEs the Provider originally reported in its 1984 cost report. The 6.38 FTEs are fully supported both by contemporaneous (1984 base year) and comparative documentation obtained following the base year.[8] This support includes: (1) the 1965 contract between the Provider and MSG noting the educational role of the MSG pathologists; (2) evidence of the comparability of Provider's pathology GME programs between 1984 and 1990 when time studies showed 6.38 FTE pathologists dedicated to GME activities; (3) the uniform result of three Intermediary-audited time studies from 1988, 1989 and 1990 supporting the 6.38 FTEs; and (4) a broad and consistent course of communications between the Provider and the Intermediary from 1988 through 1991 during which the Provider many times had informed the Intermediary of the misclassification of base year GME costs in pathology and of the need to correct this reporting without objection by the Intermediary.

The Provider notes that HCFA established a mechanism for including costs in a teaching hospital's APRA that were legitimate GME costs for the 1984 base year but had not been properly recorded in a hospital's cost center. The Provider asserts that it is entitled to this dispensation in adjusting its base year pathology GME costs due to the substantial evidence supporting the 6.38 FTEs.[9] The special circumstances of providers in waiver states like New York resulted in the Intermediary's failure to stress or even take into account GME costs. That resulted in the Provider's under-reporting of its actual and complete GME costs for its pathology department.[10]

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8 See Provider's Post-Hearing Br. 19.

9 See Provider's Post-Hearing Br. 18.

10 See Provider's Post-Hearing Br. 19.

The Provider contends that in its requested FTE adjustment for its pathology GME program, it does not seek to add or increase physician compensation costs but rather to reflect amounts the Provider actually paid to the MSG pathologists for their base year GME services and related activities.[11] The requested readjustment does not represent an attempt to obtain a "duplicate recovery" of any base year GME costs since the amounts at issue were never paid by Medicare under either Part A or Part B. HCFA's instructions to this Intermediary indicate that such base year reporting adjustments should be allowed if supported by evidence, and if not producing "duplicate payments" for the same expenses.[12] The Provider asserts that all it seeks now is that for base year purposes, actual 1984 GME costs reported (but not billed or collected) under Part B should be reclassified under Part A so that they may be included in the GME base year (and subsequent years') calculations.

The Provider contends that in the base year in New York, the Intermediary did not provide a form for physician time allocation that was properly designed to distinguish between GME and non-GME activities.[13] Further, the Intermediary failed to provide consistent guidance with respect to such allocations in the base year. In St. Luke's Hospital Medical Center v. Blue Cross Association, PRRB Dec. No. 79-D37, June 21, 1979, Medicare & Medicaid Guide ("CCH")
¶ 30,017, the Board reversed an intermediary adjustment and ordered it to pay for unbilled hospital-based Part B pulmonary physician services. The delay in billing was in part caused by inconsistent directions from the intermediary, and the provider had no other source of cost recovery. The Board determined that the payment from the intermediary would be an option preferable to sending delayed bills for unbilled services. Thus, lack of guidance from the intermediary alone is sufficient reason to reverse an intermediary determination.

The Provider contends that its request to correct the misclassifications of costs not appropriately attributed in its 1984 base year is consistent with the statutory command of 42 U.S.C.
§ 1395ww(h) and the implementing regulations at 42 C.F.R. § 413.86 et seq. In Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Co., ("Presbyterian") HCFA Admin. Dec. No. 95-D41, Aug. 7, 1995, CCH ¶ 43,691,[14] the HCFA Administrator stated that in providing for the reaudit of the GME base year, it was important that the GME base year accurately reflect legitimate GME costs because the amount recognized as reasonable would form the basis for future GME payments. Indeed, the history of the GME amendments of

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11 Id.

12 Provider's Post-Hearing Br. 41.

13 Tr. 63.

14 This decision reversed PRRB Dec. No. 95-D41, June 15, 1995, CCH ¶ 43,487.

1986 indicates that it was intended that the base year accurately reflect the correct application of the reimbursement principles in effect at the time of the base year.

The Provider observes that the Intermediary has argued that the 1965 contract's failure to segregate GME from non-GME professional time somehow indicates that MSG pathologists did not provide any compensed educational services. However, the MSG contract had been drafted in 1965, before "GME" was even a term in the vocabulary of physicians and hospital financial officers.[15] Instead, the operative contemporaneous evidence supporting the Provider's requested FTE adjustment is the actual number of residents being trained in the Provider's pathology department in 1984 based on official Provider documents created by the Provider's finance department in 1984. The Provider's witness testified that its residency program trained 19 residents in 1984 and 20 in 1990, six years later.[16] This figure was not contradicted by the Intermediary, which had full access to all of the relevant reimbursement records. Moreover, in Medical Center Hospital of Vermont v. Blue Cross and Blue Shield Association, PRRB Dec. No. 97-D27, Jan. 30, 1997, CCH ¶ 45,054, the Board allowed the provider an adjustment to its 1984 GME base year cost for its pathology residency training program based partly on a contract between the provider and the pathology physician group.

The Provider notes that the Intermediary spent much effort attempting to question the credibility of the Provider's two 1990 time studies, asserting that one showed over 33,000 annual GME pathology faculty hours while the other showed 13,000 hours. The Provider has satisfactorily explained the difference in the total annual hours devoted to GME by its pathology department physicians. The 1990 three week time study was a study of actual, raw hours worked (including on-call time)[17] while the regular time study was calibrated to a regular 40 hour work week. The Provider maintains that no pathologist works a 40 hour week, and many work more hours per week. Further, the Provider points out that the special 1990 three week study was a study of all pathology GME services while the regular two week study was only of GME laboratory activities.[18]

The Provider observes that the Board has ruled that HCFA, in its regulations and commentary, acknowledged situations in which legitimate misclassified costs were being excluded from GME base year APRAs due to the lack of contemporaneous documentation and revised its guidelines for Intermediaries to follow in assessing such costs. The documentation required in order to support reclassification of excluded GME costs need not be extensive. In Good Samaritan Hospital v. Blue Cross and Blue Shield Association, PRRB

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15 Tr. at 114.

16 Tr. at 56.

17 Tr. 89.

18 Provider's Post-Hearing Br. 16.

Dec. No. 93-D30, April 1, 1993, CCH ¶ 41,399, the Board found that a combination of the physicians' contractual agreements from the base year combined with affidavits from the current year were sufficient to justify the reclassification of costs into a GME cost center.

The Provider notes that other forms of acceptable evidence used to establish cost allocation may take the form of physical evidence, testimonial evidence, documentary evidence, and analytical evidence. Medicare Intermediary Manual, § 4112.3. If no base year documentation was available, HCFA directed that intermediaries accept documentation from time periods later than the base year itself including a special three-week time study. HCFA added that in no event would the results obtained from the use of the records from a cost reporting period later than the base period serve to increase or add physician compensation costs to the costs used to determine the per resident amounts. The Provider does not seek to add or increase physician compensation costs but to capture in its GME base the amounts it actually paid the MSG pathologists for their time dedicated to GME activities in the 1984 base year.

The Provider observes that the circumstances of this case are similar to those of Abbott Northwestern Memorial Hospital v. Blue Cross and Blue Shield Association, HCFA Admin. Dec. No. 95-D10, Feb. 2, 1995, CCH ¶ 43,136. In that case, the provider sought reclassification of certain pathology teaching physician costs from one cost center (paramedical education/laboratory cost center) to another (the intern and resident cost center). Thus, the provider sought not an increase in its costs which would have been barred by HCFA instructions, but rather an adjustment or correction of costs that had already been reported in the base year, only in an incorrect cost center. The correction of a misclassification can be applied to increase the level of costs attributable to GME cost centers in a provider's base year so long as the costs have been inadvertently omitted from the base year, or have been due to miscalculations or errors in recording costs. See Cleveland Clinic Foundation v. Blue Cross and Blue Shield Association, HCFA Admin. Dec. No. 94-D56, September 21, 1994, CCH ¶ 42,746. Without the adjustment ordered by the HCFA Administrator, the provider would have been deprived forevermore of reimbursement for its true GME costs. Those costs, like the costs in this case, were indicated by some contemporaneous documentation (physician allocation agreements) and were confirmed by the results of time studies done in 1991, seven years after the base year.

The Provider observes that the Intermediary contends that the Provider is attempting to add to its base year compensation by seeking a reallocation of base year costs that were reported as Part B, not Part A, costs. The Provider argues that: (1) nothing in the specific language of § 413.86 prohibits an adjustment such as the one requested here; (2) HCFA's own directions to the Intermediary indicated that a reclassification of costs from Part B to Part A, if justified, should only be forbidden if the reclassification would allow providers a duplicate cost recovery[19] and (3) the Provider is not seeking to reclassify billed and paid Part B costs as Part

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[19] See Provider's Post-Hearing Brief at 41.

A costs to be billed and paid. Indeed, the Intermediary contends that because the Provider did not proffer evidence of denied payments under Part B, there is no proof that the Provider was not already paid under Part B for the misclassified GME costs. However, if there was over $1 million in denied Part B claims submitted by the Provider for pathology services in the base year, then the Intermediary would be in the best position to have such claims and to produce them. The Intermediary produced no witness and no documents on this issue. The Provider maintained convincingly that there had been no Part B cost recovery and no attempted cost recovery for pathology GME services.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its exclusion of pathology professional costs attributable to resident teaching activity is proper. The costs in dispute were never claimed as medical education costs in connection with the Provider's PPS base year or GME base year cost reports. Further, the Provider did not submit auditable contemporaneous documentation for an adjustment of its as-filed classifications of operating costs for purposes of adjusting its allowable PPS and GME base year costs in accordance with the provisions of 42 C.F.R. § 413.86(j)(2).

The Intermediary argues that the Medicare regulations at 42 C.F.R. §§ 413.20 and 413.24 require providers to maintain auditable and verifiable financial and statistical records from which Medicare program costs can be determined. In Providence Medical Center v. Blue Cross and Blue Shield Association et. al., ("Providence") PRRB Decision 95-D38, May 26, 1995, CCH
¶ 43,426, aff'd, HCFA Admin. Dec., July 30, 1995, CCH ¶ 43,690, the Board held and the HCFA Administrator affirmed that the intermediary properly excluded emergency room teaching expenses from a provider's base year GME costs. It made no specific request to include the costs during the 1990 GME audit and did not claim the costs in its as-filed 1984 cost report. In 1993, subsequent to the issuance of the NAPRA, the provider submitted a current year time study to support its claim that it had incurred emergency room teaching physician expense during the base year. Inclusion of these misclassified costs as GME costs would significantly increase the APRA. However, the Board held that the result of a 1993 time study did not meet the requirements of the regulations that cost classifications be supported with adequate records. The lack of contemporaneous documentation was sufficient to deny the provider's claim for a recalculation of its APRA. In the current appeal, the Provider has not given auditable and verifiable statistical, financial, or accounting records to the Intermediary to support the costs in question.

The Intermediary notes that in Presbyterian, addressed supra, the intermediary refused to adjust the provider's APRA on the basis that the provider submitted a time study completed after the base year to support its claim that the costs of a number of teaching physicians had been misclassified. The Board held that the teaching physicians' costs should have been reclassified from operating costs to the GME cost center because 42 C.F.R. § 413.86 requires

an intermediary to determine a provider's base year APRA as accurately as possible. As in the present appeal, the provider argued that the costs at issue had been included in the base year cost report but not in the GME cost center. Therefore, the use of 1990 time studies as a proxy to add costs to the GME cost centers was appropriate in view of the lack of GME base year documentation as a result of providers having followed HCFA's record retention rules. The HCFA Administrator held otherwise, ruling that HCFA specifically advised providers in a 1990 Federal Register, 55 FR 36063, that time study results or data from later years could not be used to increase or add to physician compensation costs originally designated in the GME cost center. Because the provider failed to document its claim for increased physician compensation costs with contemporaneous documentation required by the regulations, the Board's decision was reversed. As in Providence, addressed supra, the Intermediary's refusal of the Provider's request to reclassify the physician compensation costs in dispute to the GME cost center based on 1993 time studies for purposes of determining the Provider's APRA was proper.

The Intermediary notes that the Provider indicates that it performed a three-week study to substantiate GME costs for 1984. However, the Provider did not mention the period of the time study, and more importantly, the year of the time study. The study indicated actual 1988, 1989 and 1990 physician reported time based on personal effort statements from each year resulted in GME related FTEs of 7.37, 6.38 and 6.39, respectively. These FTEs were the basis for GME reimbursement in the noted rate years. The total cost that the Provider requested to be reclassified is $1,676,747 for 4.44 FTEs. The hospital claims that the original audited pathology GME FTEs used for the APRA was 1.94. This amount, plus the equivalent of the additional FTEs for its requested cost reclassification equals 6.38 FTEs, which is near the 1990 FTE count of 6.39.

The Intermediary further contends that although it granted permission to the Provider to perform a three-week time study of 1990 supervising physicians to be used as a proxy to allocate the 1984 GME base year Part A costs in dispute, the Provider used 1988, 1989 and 1990 personal effort statements, not time studies, to support its request for the reclassification of these costs. The three-week time study does not indicate the year or the period of the time study, nor does it tie into or relate in any way to the 1990 personal effort statements. Further, personal effort statements do not qualify as time studies which must meet certain specified criteria as set forth in Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") § 2312. Neither the Provider's 1990 personal effort statements nor its three-week "time study" meet these requirements and, accordingly, this documentation is not auditable and verifiable. Therefore, the Provider's submitted contemporaneous documentation in support of its claimed GME expense is of little probative value for an increase in its APRA. It should be rejected by the Board.

The Intermediary observes that the importance placed by the Secretary on maintaining adequate, auditable and verifiable documentation in support of claimed costs has been recognized by the courts and the HCFA Administrator. See Daviess County Hospital v.

Bowen, 811 F.2d 338 (7th Cir. 1987) ("Daviess County"). In Daviess County, the Board's decision to disallow fees paid by a hospital for physical therapy services delivered in 1979 and 1980 was upheld where a provider failed to maintain appropriate time records. The district court's decision allowing reimbursement was reversed and the Secretary's decision to completely deny reimbursement in the absence of the required records was affirmed. In Bladen County Hospital v. Blue Cross and Blue Shield Association, HCFA Admin. Dec., November 1, 1985, CCH ¶ 35,046, the absence of adequate records, even if secondary sources are relied upon in an attempt to fulfill Medicare's recordkeeping requirements, was sufficient to disallow a provider's claim for reimbursement of physical therapy costs in full. Also, see Central Medical Center and Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D13, January 4, 1991, CCH ¶ 39,019 ("Central Medical Center"). In Central Medical Center, the hospital failed: (1) to maintain time records that were adequate to support its allocation of physician compensation in accordance with Medicare's recordkeeping requirements, and (2) to support its claimed allocation between Part A and Part B services. The Board affirmed the intermediary's adjustment eliminating 100% of the cost claimed by the hospital for house staff physicians. The Board should similarly affirm the Intermediary's refusal to increase the Provider's APRA in this appeal.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

42 U.S.C. § 1395ww(h)	-	Payments for Direct Medical Education Costs
§ 1861(v)(1)(A)	-	Reasonable Cost

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

§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
42 C.F.R. § 413.86	-	Direct Graduate Medical Education Payments
42 C.F.R. § 413.86(e)	-	Determining Resident Amounts For the Base Period

42 C.F.R. § 413.86(i)	-	Special Rules for States that Formerly Had a Waiver From Medicare Reimbursement Principles
42 C.F.R. § 413.86(j)	-	Adjustment of a Hospital's Target Amount or Prospective Payment Hospital-Specific Rate
42 C.F.R. § 413.86(j)(2)	-	Misclassifications of Graduate Medical Education Costs

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

§ 2312	-	Changing Cost Finding Methods

4. Program Instructions - Intermediary Manual, Part IV:

§ 4112.3	-	Standards for Performing Medicare Audits

5. Cases:

Abbott Northwestern Memorial Hospital v. Blue Cross, PRRB Dec. No. 95-D10, December 7,1994, Medicare & Medicaid Guide (CCH) ¶ 42,970 aff'd, HCFA Admin. Dec., February 2, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,136.

Bladen County Hospital v. Blue Cross and Blue Shield Association, HCFA Admin. Dec., November 1, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,046.

Cleveland Clinic Foundation v. Blue Cross and Blue Shield Association, HCFA Admin. Dec., September 21, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,746.

Daviess County Hospital v. Bowen, 811 F.2d 338 (7th Cir. 1987).

Good Samaritan Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 93-D30, April 1, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,399.

Medical Center Hospital of Vermont v. Blue Cross and Blue Shield Association, PRRB Dec. No. 97-D27, January 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,054.

Presbyterian Medical Center of Philadelphia v. Ætna Life Insurance Co. PRRB Dec. No. 95-D41, June 15, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,487, rev'd, HCFA Admin. Dec., August 7, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,691.

Providence Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 95-D38, May 26, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,426, aff'd, HCFA Admin. Dec., July 30,1995, Medicare & Medicaid Guide (CCH) ¶ 43,690.

St. Luke's Hospital Medical Center v. Blue Cross Association, PRRB Dec. No. 79-D37, June 21, 1979, Medicare & Medicaid Guide (CCH) ¶ 30,017.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the controlling law, regulations, manual instructions, facts, parties' contentions and post hearing briefs, finds and concludes that since there is no auditable documentation of detailed time studies nor a contract detailing GME responsibilities and time allocations, the Provider's request to allow reimbursement for pathology GME activity is denied. The Board finds that the Provider originally claimed the requested GME costs as Part B professional service costs. The Provider's 1965 contract with the pathology group, which was in effect during the GME base year, provided no time allocation for GME activity. It only had one small reference to teaching activity. It also did not have contemporaneous 1984 time allocation records or time studies to support its requested GME costs. Thus, no contractual or contemporaneous time records were available to support an allocation of pathology services to GME.

The Board notes that the Provider was subject to the New York waiver for reimbursement purposes and was not required under that process to keep contemporaneous documentation for allocating time to GME in 1984, the GME base year. The Board further notes that the Provider requested to do a proxy time study in 1990 from the Intermediary, and that the Intermediary granted this permission. The Provider claims to have documented time and provided the requested information to the Intermediary. However, the Intermediary states that it has not seen an adequate time study, but only personal effort statements for 1988-1990 which did not tie into the submitted 1990 study. The Board concurs and finds that the record in this case does not include an adequate study. The 1990 three-week study does not indicate the year or period of time study, nor does it tie into or agree with the personal effort statements. Thus, the Board concludes that the Provider has not adequately documented its proxy time study to allocate MSG pathology services to GME.

DECISION AND ORDER:

The Provider did not adequately document its 1990 time study nor did it have an appropriate 1984 contract or contemporaneous time records to allocate pathology services to GME. The Intermediary's adjustments are affirmed.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman