Critical Access Hospitals’
Time Study Methodology for Emergency Physician Availability Allocation
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Context: Medicare developed Critical Access Hospitals in rural, medically underserved areas to ensure necessary services would be available for elderly and disabled people. This development was meant to address financial challenges of small, rural hospitals that traditionally receive a much higher percentage of their funding from Medicare and Medical Assistance patients than larger hospitals.

Hospitals designated as Critical Access receive reimbursement based on their actual costs. In exchange for receiving cost-based reimbursement, a critical access hospital agrees to provide essential services, including a physician-staffed 24-hour emergency room and have no more than 25 inpatient beds.

The purpose of this paper is to gather resources and citations that specifically address one aspect of Critical Access Hospital (CAH) reimbursement: inclusion of costs associated with Emergency Department Physician (EDP) availability (a.k.a. standby) time in a CAH facility’s Medicare Cost Report. In particular, we will focus on methodology regarded by Centers for Medicare and Medicaid Services (CMS) as acceptable for measurement of availability time.

CMS’ Provider Reimbursement Manual is a key resource for this investigation. The following excerpts address general and specific requirements for time studies designed to measure and report availability time. Please note that the Reasonable Compensation Equivalent (RCE) computation is mentioned several times in that which follows. This limitation, addressed later in this document, does not pertain to CAH’s.

Provider Reimbursement Manual (PRM) 15-1, § 2182.3E1, Provider Recordkeeping Requirements, states:

“While they have some discretion as 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.”

CMS comments further on types of documentation that can be used as support for physician total hours in PRM 15-1, § 2182.3E 5:

“Where providers decide to employ time study techniques to substantiate either
the allocation of physicians' time to services or the actual provider services hours figure used in the RCE computation*, the provider may choose to employ the methodology described in subsection 2313.2.E, Special Applications, but the provider may not be required by the servicing intermediary to utilize that specific methodology."

The time study guidelines referred to in §2313.2E describe a one-week per month time study. This section was revised by CMS in April 1997. Prior to the 1997 revision, the time study guideline recommended a two-week per quarter time study. Since the application of RCE limits* began in 1983, a two-week per quarter time study has been accepted, and will continue to be accepted, as adequate documentation. We may require a more comprehensive time study based on audit findings for a particular provider. For example, if a time study indicates hours substantially different from hours stated in a contract, we may request a monthly instead of a quarterly time study. The provider may choose, at any time, to elect the new time study format of one week per month described below:

PRM 15-1, § 2313.2E, Special Applications – Time Studies states:

“1. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

2. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

3. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

4. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

5. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

6. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider’s request for approval and may prospectively require changes in the provider’s request as applied to subsequent cost reporting periods.”

Source: Palmetto GBA: Provider Recordkeeping Requirements for Provider Based Physicians: (http://www.palmettogba.com/palmetto/Providers.nsf/44197232fa85168985257196006939dd/85256d580043e75485257097005e7ae8?OpenDocument)
The following excerpts contribute additional detail and reinforce the methodology outlined above.

CMS Pub. 15-1 § 2109.3, “Allowability of Emergency Department Physician Availability Services Costs,” specifically addresses the special circumstances in which ER physician availability costs will be allowable.

CMS Pub. 15-1 § 2109.4 provides for two methods for determining allowable emergency physician availability services costs. It states that:

> [w]hen a provider compensates emergency physicians for being available to render physician services to individual patients in the emergency department, the provider may be reimbursed Medicare’s share of the allowable costs incurred by the provider to the extent that the costs are determined reasonable. Provider reimbursement will be based on the lesser of the actual compensation paid to the physician or the reasonable compensation determined through the application of the RCE limits to the hours of emergency department availability stipulated in the approved provider/physician allocation agreement. If the required allocation agreement does not specify the availability services hours for which the provider compensates the physician, availability service costs will not be allowable unless the conditions of §2109.4C are met with respect to minimum guarantee arrangements.

The Provider Reimbursement Manual, Part 1 (“CMS Pub. 15-1”) § 2109.1 et seq. provides for the reimbursement of hospital emergency department services when physicians receive compensation for availability services. It states that:

> [w]ide variations can occur in the utilization of hospital emergency department services and hospitals cannot always schedule physician staffing at a level commensurate with the actual volume of services rendered. As a result, emergency department physicians may spend a portion of their time in an availability status awaiting the arrival of patients. Alternatively, hospitals may need to arrange for emergency department physician coverage for evenings, weekends or holidays, when staff or community physicians are not available. Since these periods frequently generate inadequate physician revenue through charges for professional services due to lower utilization, hospitals may have to offer physicians supplemental compensation or minimum compensation guarantees to secure coverage of emergency departments.

When emergency department physicians are compensated on an hourly or salary basis or under a minimum guarantee arrangement (§2109.2E), providers may include a reasonable amount in allowable costs for emergency department physician availability services subject to limitation through the application of Reasonable Compensation Equivalents (RCEs). Availability costs will be recognized only in the emergency department of a hospital, and only as described in this section.

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As noted above, the Reasonable Compensation Equivalent computation need not be included in CAH’s Cost Report calculations for EDP availability time.

*Reasonable Cost Payment Principles that Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:
- Lesser of cost charges; and
- Reasonable compensation equivalent limits.

Source (unless otherwise noted): CMS Critical Access Hospital Fact Sheet

In exploring this topic, I found information that may allow for modification of the costs (receipt of a bonus) associated with the provision of contracted Emergency Department Physicians (outsourced specialty services), who assign their professional fees to the CAH, provided that the hospital elects an optional payment method and is located in a Physician Scarcity Area (PSA) or Healthcare Provider Shortage Area (HPSA)

Optional (Elective) Payment Method—Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)

Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:
- Reassign his or her billing rights to the CAH, agree to being included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- File claims for his or her professional services with the Carrier for standard payment under the MPFS (i.e., either by billing directly to the Carrier or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).
**Physician Scarcity Area Bonus Payments**

Primary and specialty physicians affiliated with a CAH may also be eligible for a Physician Scarcity Area (PSA) bonus payment of five percent if the CAH is located in an area with few physicians available. One of the following modifiers must accompany the Healthcare Common Procedure Coding System code to indicate the type of physician:
- AG—Primary physician; or
- AF—Specialty physician.

If a CAH located in a PSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent.

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**Primary or Specialty Physician?**


Only the provider designations of General Practice (01), Family Practice (08), Internal Medicine (11), and Obstetrics/Gynecology (16) will be paid the bonus for the zip codes designated as primary care PSAs. All other physician provider specialties will be eligible for the specialty physician scarcity bonus for the zip codes designated as specialty PSAs.

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**Health Professional Shortage Area Incentive Payments**

If the CAH is located within a primary medical care Health Professional Shortage Area (HPSA), physicians who furnish outpatient professional services in the CAH are eligible for a 10 percent HPSA incentive payment. If a CAH located in such a HPSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent.


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**Time Studies**

This leads us to acceptable methodologies for time studies... A word of caution here: That which follows is based on generally accepted common practice, deemed acceptable by selected Medicare Fiscal Intermediaries. As I was unable to find citations from CMS specifying methodology, what you’ll find recorded here represents observation rather than a directive from CMS. The following list is likely not inclusive. There may be additional, acceptable methodologies available. **Please consult your Fiscal Intermediary before implementing any of these strategies.**
1. Using the ED Patient Log

In this method, the facility uses the times recorded in the log (which includes time of arrival and discharge for each patient) as the basis of determining when there were no patients in the department. While use of this method provides an indication of when the physician is not engaged in clinical duties (as there are no patients in the department) it is not truly representative of the definition of availability. It is likely that there are instances where there are patients in the department, but the ED Physician is not actively engaged in clinical duties.

2. Using a Time Study Completed by the ED Physicians

As the ED Physicians are responsible for the data regarding their availability submitted by the facility (in their Cost Report) on their behalf, it is logical to provide a mechanism for them to personally record, during each shift during the time study period, their impression of the division of time between clinical and “standby”. An excerpt of one such document is reproduced below. Legend for the document is as follows: (1) Clinical, (2) Standby, and (3) Administrative. This methodology has the advantage of near contemporaneous record keeping by the individuals performing the Medicare-reimbursed services. Its’ only limitation is the subjective nature of memory and the devotion (or lack thereof) to accuracy of the physicians.

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3. Radio Frequency Identification (RFID) Tracking

An emerging possibility for enhancement of accuracy in recording and reporting ED Physician availability time involves implementation of an RFID tag and detector system in the department. One such implementation, at an ACUTE
CARE-affiliated hospital in Hicksville, Ohio (http://ertracker.com/inaction.htm), has led our organization to explore this technology with the goal of developing an RFID system that meets the requirements of our practices. As of this writing, we are preparing for ED-based testing as the prelude to our first implementation.

This paper is the latest in a series of investigations by ACUTE CARE, INC. designed to respond to our partner facilities’ challenges as a partner and resource. In this case we sought to gather citations that specifically address Emergency Department Physician (EDP) availability (a.k.a. standby) time in a CAH facility’s Medicare Cost Report. It was our goal to explore methodology regarded by CMS as acceptable for measurement of availability time and to share existing and emerging time study systems. We hope that the results of the investigation are beneficial, and look forward to a continued dialogue on this important topic.

Respectfully Submitted,

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