PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2023-D32

PROVIDER-
Bon Secours Memorial Regional Medical Center

Provider No.:
49-0069

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services

RECORD HEARING DATE –
June 22, 2022

Fiscal Year Ending –
Various (2010-2013)

CASE NOS. –
15-2971, 15-3228,
16- 2290, 17-0907

CONTENTS

ISSUE STATEMENT

Whether the Provider is entitled to receive reimbursement for its Medicare Part C Managed Care costs incurred through its nursing and allied health ("NAH") program, based on the requirements in 42 C.F.R § 413.87, when the Provider submitted no-pay bills to the Medicare Contractor in the UB-92 format but the claimed costs in those bills were not captured in the Provider Statistical and Reimbursement Report ("PS&R") data[1] for the Provider's fiscal years ("FYs") 2010 through 2013.[2]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds that the Medicare Contractor properly adjusted the Provider's NAH Part C Managed Care payment for FYs 2010 through 2013 to exclude the Medicare Part C data associated with the no-pay bills at issue.

INTRODUCTION

Bon Secours Memorial Regional Medical Center (the "Provider" or "Bon Secours") is a general short-term hospital located in Mechanicsville, Virginia.[3] The Medicare contractor[4] assigned to Bon Secours for these appeals is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").

Bon Secours offers nursing educational programs and/or allied health professional education ("NAH") programs. Bon Secours contends that, for FYs 2010 through 2013, it met the requirements of 42 C.F.R. § 413.87 and was underpaid for its Medicare Part C Managed Care ("Part C")[5] costs incurred through its NAH program.[6]

Bon Secours timely appealed the Medicare Contractor's final determinations for FYs 2010 through 2013 and has met the jurisdictional requirements for a *consolidated* hearing before the Board. On June 22, 2022,[7] the Board approved a *consolidated* record hearing for the FY 2010 through 2013 cases and is issuing a *consolidated* decision. Bon Secours was represented by

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[1] The PS&R Report is a series of reports which capture statistical and reimbursement data for Medicare Part A claims. *See* https://www.cms.gov/medicare/compliance-and-audits/part-a-cost-report-audit-and-reimbursement/psandr#:~:text=Overview,finalized%20Medicare%20Part%20A%20claims (last visited July 20, 2023).

[2] Stipulations (hereinafter "Stip.") at ¶ 1.4 (Feb. 28, 2022).

[3] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2 (Case No. 15-2971) (Jul. 1, 2019).

[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but 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.

[5] Medicare Part C Managed Care costs are incurred under what is referred to as the Medicare Advantage Program (formerly known as the Medicare+Choice Program or M+C) which provides an alternative to the traditional Medicare "fee for service" program and allows Medicare beneficiaries to enroll in a health maintenance organization ("HMO"), preferred provider organization ("PPO") or other private managed care plans. If an individual with Medicare opts to enroll in a Medicare Advantage plan, the Secretary makes payments to the plan instead of making payments to other providers under Parts A or B. *See* 42 U.S.C §§ 1395w-21-1395w-29.

[6] Provider's Optional Response Brief (hereinafter "Provider's Response") at 1 (Case No. 15-2971) (Aug. 12, 2019).

[7] The Board approved the addition of Case Nos. 16-2290 and 17-0907 on August 19, 2022.

Daniel J. Hettich, Esq. of King & Spalding LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS AND RELEVANT LAW

This dispute centers on whether the Medicare Contractor properly calculated Bon Secours' NAH payments for FYs 2010 through 2013. Bon Secours alleges the Medicare Contractor failed to include all of its Part C patient days in the calculation of its NAH payments for these years.[8]

A. Nursing and Allied Health Education Programs

From the inception of the Medicare program in 1965, certain medical education expenses have been reimbursed on a reasonable cost basis.[9] Both the House and Senate Committee reports accompanying the 1965 legislation[10] suggest that Congress favored including medical educational expenses as allowable medical education costs under the Medicare program. The following statements from the Congressional committee reports address the reimbursement of medical education costs as allowable expenses under the Medicare program and reflect the Congressional inclination regarding reimbursement of medical education expenses:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[11]

Significantly, these reports specifically list nursing and paramedical (*i.e.*, NAH) education expenses as a type of medical education activity that "should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program [*i.e.*, the Medicare program]."[12]

In 1999, Congress enacted the Balanced Budget Refinement Act ("BBRA") and, in § 541(a), added 42 U.S.C. § 1395ww(1) to provide for additional payments to be made to qualifying hospitals to cover the costs of Medicare Managed Care patients associated with approved NAH programs.[13] This statutory provision describes the methodology for determining the additional payments and sets forth the rules for determining an additional payment amount for any qualifying hospital that receives payments for its costs of operating approved NAH education programs under

[8] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 1 (Case No. 15-2971) (June 12, 2019).
[9] *See* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.421 (1966); 57 Fed. Reg. 43659, 43661 (Sept. 22, 1992).
[10] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).
[11] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).
[12] *Id*.
[13] Pub. L. 106-113, Appendix F § 541(a), 113 Stat. 1501A-321, 1501A–391 (1999).

42 C.F.R § 413.85. The Secretary implemented BBRA § 541(a) at 42 C.F.R. § 413.87 to set forth the qualifying conditions that must be met in order for a hospital to receive an additional payment amount associated with Part C Managed Care utilization.[14]

In 2000, Congress passed the Benefits Improvement and Protection Act ("BIPA") and, in § 512(a), amended 42 U.S.C. § 1395ww(1)(2)(C) to change the formula for determining NAH Part C Managed Care payments by adding consideration of a provider's Part C Managed Care utilization.[15] Specifically, for cost reporting periods beginning on or after January 1, 2001, hospitals operating NAH programs could receive additional payment amounts if: (i) the hospital received reasonable cost Medicare payment for a NAH program in its cost reporting period ending in the federal fiscal year two years prior to the current calendar year; (ii) the hospital is receiving reasonable cost payments for its NAH program in the current calendar year; and (iii) the hospital has a Part C Managed Care utilization greater than zero in its cost reporting period ending in the fiscal year that is two years prior to the current calendar year.[16] Accordingly, in the final rule published on June 13, 2001, the Secretary implemented BIPA § 512(a) by revising 42 C.F.R. § 413.87.[17]

On February 3, 2003, CMS issued Program Memorandum, Transmittal A-03-007 ("PM A-03-007"), which outlined the Medicare contractor and standard system changes needed to process NAH education supplemental payments for Part C Managed Care enrollees.[18] PM A-03-007 updated the 1998 Program Memorandum under Transmittal A-98-21 ("PM A-98-21"),[19] which explained the methodology for processing direct graduate medical education ("DGME") and indirect medical education ("IME") payments associated with Part C Managed Care enrollees effective January 1, 1998. PM A-03-007 effectively instructed hospitals that operate a NAH program and qualify for additional payments related to their Part C enrollees under 42 C.F.R. § 413.87(e), to submit their Part C claims to their regular Medicare contractor to be processed as no-pay bills in UB-92 format, *with condition codes 04* ***and*** *69*, so that the Part C inpatient days can be accumulated on the PS&R report type 118 for purposes of calculating the Part C NAH payment through the cost report process.

The cost report instructions for Worksheet E, Part A are located in the Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 4030, and they explain that the NAH Managed Care payment, for Line 53, is obtained from the provider's Medicare contractor.[20] On May 23, 2003, CMS issued Program Memorandum, Transmittal A-03-043 ("PM A-03-043"), distributed to the Medicare contractors, explaining the required steps to calculate the hospital's NAH payment.[21] Included in Step 1 of these steps was a specific instruction to obtain the number of Part C inpatient

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[14] *See* 65 Fed. Reg. 47026, 47051-52 (Aug. 1, 2000) (initial codification of 42 C.F.R. § 413.87).
[15] Pub. L. 106-554, Appendix F § 521(a), 114 Stat. 2763A-463, 2763A-533 (2000).
[16] *Id.*
[17] 66 Fed. Reg. 32172, 32195-96 (June 13, 2001) (revising 42 C.F.R. § 413.87(c)(1)-(2)).
[18] Program Memorandum, CMS Pub. 60A, Transmittal A-03-007 (Feb. 3, 2003) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03007.pdf (last visited Sept. 8, 2023).
[19] Program Memorandum, HCFA Pub 60-A, Transmittal A-98-21 (July 1, 1998) (NOTE: CMS was formerly known as the Health Care Financing Administration or "HCFA").
[20] Ex. C-2 (Case No. 15-2971).
[21] Program Memorandum, CMS Pub. 60A, Transmittal A-03-043 (May 23, 2003) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03043.pdf (last visited Sept. 8, 2023).

days from the PS&R, report type 118.[22] The Transmittal notes that, "subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual [CMS Pub. 13], additional documentation to revise the [Medicare contractor's] FI's determination may be submitted by the provider."[23]

B. Stipulations

The parties have stipulated to certain facts and principles of law in each of the four appeals, which cover four distinct cost reporting periods – FYs 2010 through 2013. Across these cost years, the stipulations are relatively similar, with differences identified, based on specific cost year data. These stipulations are summarized, in the aggregate and in pertinent part, as follows:

> I. **Background**
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> 1.5 In Case No. 15-2971, in lieu of claiming NAH Part C payment on Line 11.01 of Worksheet E, Part A, the Provider reported a protested amount of the NAH Part C payment it claimed it is owed on Line 30 of Worksheet E Part A. *See* Case No. 15-2971, Exhibits C-5 and C-6.
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> In Case No. 15-3228, in lieu of claiming NAH Part C payment on Line 53 of Worksheet E Part A, the Provider reported a protested amount of the NAH Part C payment it claimed it is owed on Line 75 of Worksheet E Part A. *See* Case No. 15-3228, Exhibits C-5 and C-6.
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> 1.6 The [Medicare Contractor] issued the following four [NPRs]:
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> a) On January 14, 2015, . . . an NPR for the Provider's [FY] 2010,[24]
> b) On February 19, 2015, . . . an NPR for the Provider's [FY] 2011,[25]
> c) On February 16, 2016, . . . an NPR for the Provider's [FY] 2012;[26] and
> d) On August 4, 2016, . . . an NPR for the Provider's [FY] 2013.[27]
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> 1.7 In Case No. 15-2971, in the audit adjustment report accompanying the NPR, the [Medicare Contractor] in adjustment number 17, removed the reported protested amount claimed which included an amount relating to a NAH Managed Care Payment.

[22] Ex. C-3 (Case No. 15-2971).
[23] PM A-03-043 at 2.
[24] Stip. at ¶ 1.6 (Case No. 15-2971).
[25] Stip. at ¶ 1.6 (Case No. 15-3228) (Feb. 28, 2022).
[26] Stip. at ¶ 1.4.1 (Case No. 16-2290) (Feb. 28, 2022).
[27] Stip. at ¶ 1.4.1 (Case No. 17-0907) (Feb. 28, 2022).

In Case No. 15-3228, in the audit adjustment report accompanying the NPR, the [Medicare Contractor] in adjustment number 15, removed the reported protested amount relating to a NAH Managed Care Payment.

In Case No. 16-2290, in the audit adjustment report accompanying the NPR, the [Medicare Contractor] in adjustment number 22, increased the amount reported on Line 53 of Worksheet E Part A of the as-filed cost report from $639, 678 to a value of $1,206,097 associated with NAH.[28]

In Case No. 17-0907, in the audit adjustment report accompanying the NPR, the [Medicare Contractor] in adjustment number 25, decreased the amount reported on the as-filed cost report from $1,319,888 to a value of $1,241,661 for NAH Part C payment on Line 53 of Worksheet E Part A.[29]

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II. Facts Related to the Appeals

2.1 In Case No. 15-2971, at issue is the Provider's NAH Part C payment determinations for calendar years 2009 and 2010 insofar as they overlap with the Provider's cost reporting period spanning September 1, 2009 through August 31, 2010.

In Case No. 15-3228, at issue is the Provider's NAH Part C payment determinations for calendar years 2010 and 2011 insofar as they overlap with the Provider's cost reporting period spanning September 1, 2010 through August 31, 2011.

In Case No. 16-2290, at issue is the Provider's NAH Part C payment determinations for calendar years 2011 and 2012 insofar as they overlap with the Provider's cost reporting period spanning September 1, 2011 through August 31, 2012.

In Case No. 17-0907, at issue is the Provider's NAH Part C payment determinations for calendar years 2012 and 2013 insofar as they overlap with the Provider's cost reporting period spanning September 1, 2012 through August 31, 2013.

2.2 One of the principal data points for determining a provider's NAH Part C payment for a given calendar year is the number of inpatient days attributable to Part C beneficiaries during the provider's cost reporting period ending in the federal fiscal year that is two years preceding the payment year.[30]

[28] Stip. at ¶ 1.4.2 (Case No. 16-2290).
[29] Stip. at ¶ 1.4.2 (Case No. 17-0907).
[30] Stip. at ¶ 2.2 in Case Nos. 15-2971, 15-3228; Stip. at ¶ 2.1.1 in Case Nos. 16-2290, 17-0907.

2.3 In Case No. 15-2971, for the purposes of the Provider's NAH Part C payment determination for calendar years 2009 and 2010, the applicable Part C days are those from the Provider's two prior fiscal year ending ("FYEs") August 31, 2007 and 2008.

In Case No. 15-3228, for the purposes of the Provider's NAH Part C payment determination for calendar years 2010 and 2011, the applicable Part C days are those from the Provider's two prior FYEs August 31, 2008 and 2009.

In Case No. 16-2290, for the purposes of the Provider's NAH Part C payment determination for calendar years 2011 and 2012, the applicable Part C days are those from the Provider's prior FYEs August 31, 2009 and 2010.[31]

In Case No. 17-0907, for the purposes of the Provider's NAH Part C payment determination for calendar years 2012 and 2013, the applicable Part C days are those from the Provider's prior FYEs August 31, 2010 and 2011.[32]

2.4 During the periods named in Stipulation 2.3 [or 2.1.2], the Provider has submitted to the [Medicare Contractor] UB-04 CMS 1450 ("UB-04') forms reflecting Part C days during the relevant prior two FYEs.

2.5 The UB-04 forms submitted by the Provider reflected the use of condition code "04" to designate it as an "informational only bill" (a "Shadow Bill" [also known as a "no-pay" bill]).[33]

2.6 For each of the relevant two prior FYEs stated in Stipulation 2.3 [or 2.1.2], the Provider's Shadow Bills using condition code 04 were used by the [Medicare Contractor] for purposes of calculating the Provider's Part C days in the Medicare fraction of the DSH calculation, and such days were included in the Provider's MedPAR file.[34]

2.7 In Case No. 15-2971, the number of Part C days indicated on the Provider's MedPAR file was 2,387 Part C days.

In Case No. 15-3228, the number of Part C days indicated on the Provider's MedPAR file was 2,387 Part C days for 2008 and 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009.[35]

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[31] Stip. at ¶ 2.1.2 (Case No. 16-2290).
[32] Stip. at ¶ 2.1.2 (Case No. 17-0907).
[33] Stip. at ¶ 2.1.4 (Case Nos. 16-2290, 17-0907).
[34] Stip. at ¶ 2.1.5 (Case Nos. 16-2290, 17-0907).
[35] The Provider's MedPAR data indicate a total of 4,709 days corresponding to Part C beneficiaries' length of stay and 4,701 days as Part C covered days for 2009. For purposes of these stipulations of fact, the Parties present both amounts for consideration by the Board as it relates to the 2009 data.

In Case No. 16-2290, the number of Part C days indicated on the Provider's MedPAR file was 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009 and 4,904 Part C days for 2010.[36]

In Case 17-0907, the number of Part C days indicated on the Provider's MedPAR file was 4,904 Part C days for 2010 and 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011.[37]

2.8 The Provider's Shadow Bills did not use condition code "69" to designate the shadow bill as one for a teaching hospital.[38]

2.9 In Case No. 15-2971, the absence of condition code 69 on the Provider's Shadow Bills caused the NAH Managed Care data of 2,387 Part C days to be omitted from the Provider's PS&R report type 118.

In Case No. 15-3228, the absence of condition code 69 on the Provider's Shadow Bills caused the NAH Managed Care data of 2,387 Part C days for 2008 and 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009 to be omitted from the Provider's PS&R report type 118.

In Case No. 16-2290, the absence of condition code 69 on the Provider's Shadow Bills caused the NAH Managed Care data of 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009 and 4,904 Part C days for 2010 to be omitted from the Provider's PS&R report type 118.[39]

In Case No. 17-0907, the absence of condition code 69 on the Provider's Shadow Bills caused the NAH Managed Care data of 4,904 Part C days for 2010 and 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011 to be omitted from the Provider's PS&R report type 118.[40]

2.10 The [Medicare Contractor] relied on the Provider's PS&R reports type 118 and the FYE 08/31/2008, 08/31/2009, 08/30/2010, and 08/31/2011 cost reports to calculate the Part C days for the Provider's Part C NAH payment.[41]

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[36] *Id.* *See also* Stip. at ¶ 2.1.6 (Case No. 16-2290).
[37] The Provider's MedPAR data indicate a total of 3,373 days corresponding to Part C beneficiaries' length of stay and 3,357 days as Part C covered days for 2011. For purposes of these stipulations of fact, the Parties present both amounts for consideration by the Board as it relates to the 2011 data. *See also* Stip. at ¶ 2.1.6 (Case No. 17-0907).
[38] This data is reflected in Stip. at ¶¶ 2.8 (Case Nos. 15-2971, 15-3228) and 2.1.7 (Case Nos. 16-2290, 17-0907).
[39] Stip. at ¶ 2.1.8 (Case No. 16-2290).
[40] Stip. at ¶ 2.1.8 (Case No. 17-0907).
[41] This data is reflected in Stip. at ¶¶ 2.10 (Case Nos. 15-2971, 15-3228) and 2.1.9 (Case Nos. 16-2290, 17-0907).

2.11 In each of these four appeals the Provider filed a final position paper in the Office of Hearings Case and Document Management System ("OH-CDMS") on June 12, 2019. The Provider submitted MedPAR data as an exhibit to each position paper.[42]

In Case No. 15-2971, the final position paper exhibit indicates 2,387 Part C days during this period.

In Case No. 15-3228, the final position paper exhibit indicates 2,387 Part C days for 2008 and 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009.

In Case No. 16-2290, the final position paper exhibit indicates 4,709 Part C length of stay days (including 4,701 Part C covered days) for 2009 and 4,904 Part C days for 2010.[43]

In Case No. 17-0907, the final position paper exhibit indicates 4,904 Part C days for 2010 and 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011.[44]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

As shown above, the Medicare Contractor and Bon Secours have stipulated in each of these four appeals that, while Bon Secours used condition code "04" on the Part C bills at issue to designate them as no-pay or information-only bills, Bon Secours *failed* to use condition code "69" to designate those no-pay bills *as pertaining to a teaching hospital* (whether DGME or NAH). The Parties also have stipulated that the absence of condition code 69 on the no-pay bills at issue caused the NAH Managed Care data associated with those no-pay bills to be omitted from Bon Secours' PS&R Report Type 118 for each fiscal year under appeal.[45] However, contrary to the parties' stipulations, Bon Secours' Exhibit P-5 in Case No. 17-1907 (PS&R Report Type 118 covering FYs 2010, 2011, and 2012, run November 27, 2012) confirms that Bon Secours *did begin* to properly bill no-pay claims (*i.e.*, using both condition codes 04 ***and*** 69), at some point during FY 2010 or later, *for discharges occurring in its FY 2010* (*i.e.*, discharges occurring between September 1, 2009 and August 31, 2010). Specifically, the PS&R Type 118 Report confirms that Bon Secours submitted no-pay bills, using both condition codes 04 and 69, for 2,274 Part C days for FY 2010, 3,384 Part C days for FY 2011, and 3,277 Part C days for FY 2012.

Similar to the preamble to the final rule published on May 12, 1998 (the "1998 Final Rule") and PM A-98-21 for DGME, PM A-03- 007, plainly instructed Bon Secours to bill claims for Part C Managed Care enrollees for NAH program. Specifically, the PM instructs Hospitals operating an NAH program to submit the Part C Managed Care claims to be processed as a no-pay bill using the

[42] This data is reflected in Stip. at ¶¶ 2.11 (Case Nos. 15-2971, 15-3228) and 2.3 (Case Nos. 16-2290, 17-0907).
[43] Stip. at ¶ 2.3 (Case No. 16-2290).
[44] Stip. at ¶ 2.3 (Case No. 17-0907).
[45] *See* Stip. at ¶¶ 2.8, 2.9 (Case Nos. 15-2971, 15-3228), ¶¶ 2.1.7, 2.1.8 (Case Nos. 16-2290, 17-0907) (also provided is the number of Part C days omitted from each relevant PS&R Report Type 118).

UB-92 format on the form CMS-1450[46] *with condition codes 04* ***and*** *69* so that the Part C inpatient days could be accumulated on the PS&R (report type 118) for purposes of calculating the Part C NAH payment on the relevant cost report.[47] The Medicare Contractor argues that Bon Secours "must file a UB-04 claim form through the claims processing system in order to calculate the [NAH] payment for [Part C Managed Care] enrollees", and that Bon Secours' claims "must be timely submitted as required by 42 C.F.R. §424.44."[48] The Medicare Contractor further states that the requirement to bill no-pay claims for Part C Managed Care enrollees was communicated to hospitals *well before* the finalization of Bon Secours' FY 2008 cost reporting period.[49] The Medicare Contractor notes "[t]he method of receiving payment for DGME for [Part C] enrollees was specifically addressed by CMS in the Federal Register dated May 12, 1998."[50] The Medicare Contractor contends that it used the best available data when reviewing and calculating Bon Secours' NAH payment.[51]

In its Final Position Paper, Bon Secours argues that PM A-03-043 provides "specific steps for the '[Medicare Contractor] to follow when calculating the additional [NAH Part C Managed Care] payment. . ."[52] The Medicare Contractor argues that "CMS identifies the data source for the [Medicare Contractor's] calculation of NAH [Part C] Manage[d] Care payments as the PS&R report type 118."[53] However, for certain of the periods at issue, the Medicare Contractor notes that Bon Secours' PS&R reports type 118 did not report any Part C days.[54]

Bon Secours states it submitted a total of 2,387 Part C days for services in FY 2008.[55] The Medicare Contractor argues that it is "the Provider's responsibility to seek to have the [Part C] days corrected on its FYE 8/31/2008 cost report via a reopening. The [Part C] days reported on Worksheet S-3, Column 4, Line 2 for the FYE 8/31/2008 should include PS&R Report Type 118 hospital days to be used in the [NAH] payment calculation for FYE 8/31/2010."[56] While the Medicare Contractor did not scope NAH for review, based on CMS thresholds, Bon Secours "should have been aware that its PS&R reflected a different number of [Part C] days as a result of no-pay claims than what its records indicated."[57] As the Medicare Contractor notes, the PS&R report is integral to the cost report preparation, audit, and settlement processes and, to that end, providers have access to the PS&R for those purposes.[58] Accordingly, for FY 2008, for example,

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[46] When PM A-03-007 was issued, the form CMS-1450 used a UB-92 format and was also referred to as the UB-92. The form CMS-1450 was later revised to update the UB-92 format, replacing it with a UB-04 format and, as a result, it is now also known as the UB-04. *See* Medicare Claims Processing Manual, CMS Pub. 100-04, Transmittal 1254 (May 24, 2007) available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1254CP.pdf (last visited Sept. 8, 2023); https://www.cms.gov/medicare/coding-billing/electronic-billing/institutional-paper-claim-form (last visited Sept. 8, 2023).
[47] CMS Transmittal A-03-007 at 1.
[48] Medicare Contractor's FPP at 9 (Case No. 15-2971).
[49] *Id.* at 13.
[50] *Id.* at 14.
[51] *Id.* at 8.
[52] Provider's FPP at 5 (Case No. 15-2971).
[53] Medicare Contractor's FPP at 8 (Case No. 15-2971).
[54] *Id.*
[55] Stip. at ¶ 2.11 (For purposes of argument, which are similar in all four FYs, FY 2008 will be used for narrative purposes).
[56] Medicare Contractor's FPP at 8 (Case No. 15-2971).
[57] *Id.*
[58] *Id.* at 9; https://www.cms.gov/data-research/statistics-trends-and-reports/provider-statistical-reimbursement-report

Bon Secours could have used the PS&R report type 118 in preparing its FY 2008 cost report to identify the issue and then pursued correction by re-billing the claims, and revising the FY 2008 cost report, through an amended cost report, or a reopening, as necessary.

The Medicare Contractor cites to the Administrator's decisions in *Santa Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n* and *Sutter 98-99 Managed Care (CIRP) Grp. v. BlueCross BlueShield Ass'n,* in which the Administrator held that the "pre-existing methodology requires that claims be made to the intermediary in order to generate a payment."[59] Further, "the requisite claims were reasonably required to be submitted to the Intermediary pursuant to 42 CFR § 424.30, § 424.32, and § 424.44."[60] The Medicare Contractor requests that the Board affirm the adjustment as the Medicare Contractor appropriately included the correct number of Medicare Part C days based on the data included in the PS&R.[61]

Bon Secours contends that "it met the requirements of 42 C.F.R. § 413.87 and should receive full reimbursement for its Medicare Managed Care costs incurred through its [NAH] program."[62] Bon Secours states it did, in fact, treat Medicare managed care patients and did submit "no-pay" or "shadow" bills for FYs 2009 and 2010; but that, "[f]or reasons unknown and beyond the Provider's control, none of the shadow bills that [it] submitted during its FYEs August 31, 2007 and 2008 were reflected in [PS&R Reports] for that period."[63] Accordingly, Bon Secours maintains that the Medicare Contractor "improperly omitted certain of the Provider's [Part C] days on Worksheet S-3 Part 1, Column 4, Line 2 on the Provider's cost report, despite proper shadow billing"[64] resulting in an underpayment.

Bon Secours asserts that it is ultimately the Medicare Contractor's responsibility to calculate the NAH Part C Managed Care payments correctly.[65] In this regard, Bon Secours notes:

> The regulations do not specify the data source from which the [Medicare contractor] or CMS will obtain information regarding a provider's Medicare Managed Care days in order to calculate the payment. CMS stated in rulemaking that it will use "the best available cost reporting data . . . from HCRIS" to determine these payments. 66 Fed. Reg. 32172, 32179 (June 13, 2001) (regarding use of best available cost report data). PS&R data is mentioned nowhere in the regulation or rulemaking.[66]

(CMS webpage describing the importance of the PS&R report and providers' access to it). *See also* PRM 15-2 § 104 (describing how Medicare contractors can provide copies of the PS&R).

[59] *Santa Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n,* Adm'r Dec. at 13 (Nov. 16, 2007), *reversing* PRRB Dec. 2007-D78 (Sept. 28, 2007).

[60] *Sutter 98-99 Managed Care (CIRP) Grp. v. BlueCross BlueShield Ass'n,* Adm'r Dec. at 20 (Aug. 16, 2011), *reversing* PRRB Dec. 2011-D34 (June 16, 2011).

[61] Medicare Contractor's FPP at 18-19 (Case No. 15-2971).

[62] Provider's Response at 1 (Case No. 15-2971).

[63] Provider's FPP at 1 (Case No. 15-2971).

[64] *Id.*

[65] *Id.* at 4.

[66] *Id*.

Bon Secours contends that, because the PS&R report type 118 did not accurately capture its Part C days, the Medicare Contractor is required to use *other auditable data* to accurately calculate its NAH Part C Managed Care payment.[67] However, according to Bon Secours, "[t]he [Medicare Contractor] severely underestimated this calculation on line 53 of Worksheet E, Part A in its audit of the Provider's cost report."[68]

In support of its contention that the Medicare Contractor should have used other auditable data, Bon Secours points to the instructions in PM A-03-043. Bon Secours recognizes that PM A-03-043 directs Medicare contractors to "obtain the number of [Part C] inpatient days from the . . . [PS&R] report type 118" but notes that it also specifies that "additional documentation to revise the [Medicare contractor's] determination *may* be submitted by the provider, but will be subject to audit by the [Medicare contractor]."[69] Bon Secours cites to Board decisions where the Board directed the Medicare Contractor to consider such other "additional documentation" outside of the PS&R report:

1. *Campbell's Provider Care, Inc*., PRRB Dec. 2001-D22 (May 2, 2001) in which the Board allowed the provider "to submit evidence of inaccurate PS&R data."[70]

2. *Santa Barbara Cottage Hospital*, PRRB Dec. 2007-D78 (Sept. 28, 2007), in which the Board "held that the failure to capture a provider's Medicare Managed Care data being on the PS&R report was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[71]

Accordingly, Bon Secours maintains that, consistent with PM A-03-043 and these Board decisions, it has supplied alternative auditable documentation of its no-pay billing and corresponding remittance from the Medicare Contractor.[72] Further, Bon Secours asserts that this alternative auditable documentation should be used to adjust its NAH Part C Managed Care payment for FYs 2010 to 2013.[73]

Lastly, Bon Secours argues the Medicare Contractor's required use of the PS&R Report type 118 (at the exclusion of the other auditable data) violates the Notice and Comment required by both the Administrative Procedure Act and the Medicare Act. Specifically, "[b]ecause the [Medicare Contractor's] policy to use PS&R report 118 data at the exclusion of other auditable data proffered by the Provider did not undergo notice-and-comment rulemaking, it cannot be enforced in a way that deprives the Provider of its due NAH Part C payment."[74] Accordingly, Bon Secours requests that the Board instruct the [Medicare Contractor] to correct its PS&R report type 118 to reflect the correct amount in its MEDPAR-validated data.[75]

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[67] *Id.* at 7.
[68] Provider's FPP at 9 (Case No. 16-2290). While the Provider only makes this exact statement in the two later year appeals (Case Nos. 16-2290, 17-0907), there is no indication it is not applicable for all years under appeal.
[69] Provider's FPP at 8 (Case No. 15-2971) (citing to PM A-03-043 at 2) (emphasis added).
[70] *Id.* at 9.
[71] *Id*. (NOTE: The Provider's citation to "05-1327 et al" reflects the PRRB case number, not the decision number, which was PPRB Dec. 2007-D78. The cited date of September 8, 2007 is correct.).
[72] *Id.*
[73] *Id.* at 9-10.
[74] *Id*. at 11-12.
[75] *Id.* at 13.

42 U.S.C. § 1395ww(1) provides for additional payments to hospitals that operate NAH programs. The statutory provision was implemented at 42 C.F.R § 413.85 which allows for additional payments associated with Part C Managed Care utilization *if qualifying conditions are met under § 413.87(c)*. Bon Secours contends that it has met the requirements of § 413.87 and should receive reimbursement for its Part C Managed Care costs incurred through its NAH program.[76] Section 413.87(e) specifies that the additional payment amount is determined according to the following steps:

> (e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001*. For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in [Part C Managed Care] direct GME payments, the additional payment amount specified in paragraph (c) of this section **is calculated according to the following steps**:
>
> (1) *Step one*. Each calendar year, determine for each eligible hospital the total –
>
> (i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and
>
> (ii) Inpatient days for that same cost reporting period.
>
> (iii) [Part C] inpatient days for that same cost reporting period.
>
> (2) *Step two*. Using the data from step one, determine the ratio of the individual hospital's total and nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total [Part C] inpatient days.
>
> (3) *Step three*. CMS will determine, using the best available data, for all eligible hospitals the total of all –
>
> (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
>
> (ii) Inpatient days from those same cost reporting periods; and
>
> (iii) [Part C] inpatient days for those same cost reporting periods.

[76] Provider's Response at 1 (Case No. 15-2971).

> (4) *Step four*. Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all [Part C] inpatient days for those same cost reporting periods.
>
> (5) *Step five*. Calculate the ratio of the product determined in step two to the product determined in step four.
>
> (6) *Step six*. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

The Board finds the intent of the regulation is to *accurately* provide reimbursement to *all* providers who participate in approved NAH programs. The methodology formulated by CMS takes into account the data provided by each provider to calculate the *total reimbursement for* ***all*** *of the participating providers* ***with qualifying NAH programs***. The Board notes the importance of providers submitting accurate information to CMS for accurate reimbursement. In this instance, Bon Secours erroneously submitted NAH payment reimbursement which potentially distorted the data for ***all*** NAH participant providers.

First, for FYs 2010 and 2011, Bon Secours failed to report an NAH claim for payment on the appropriate line of Worksheet E, Part A on its submitted cost report and, instead, it reported a protested amount on the appropriate line of Worksheet E, Part A.[77] During the desk review process, the Medicare Contractor reviewed and removed this amount. For FYs 2012 and 2013, Bon Secours reported an NAH claim for payment but the Medicare Contractor only allowed an NAH payment relative to Part C days listed on the PS&R report type 118 for the relevant time periods.[78] The cost report instructions for Worksheet E, Part A at PRM 15-2 § 4030 state: "Line 53--Enter the amount of nursing and allied health managed care payments if applicable."[79] Importantly, the cost report instructions reference PM A-03-043. On May 23, 2003, CMS issued PM A-03-043 which describes the steps to calculate the hospital's NAH payment and, in particular, states:

> Step 1: Determine for each eligible hospital the—
>
> ****

[77] Stip. at ¶ 1.5 (Case Nos. 15-2971, 15-3228). The version of the cost report used for FY 2010 is the form CMS-2552-96 in which NAH Part C payments were reported on Line 11.01 of Worksheet E, Part A, as relevant, and any protested amounts were reported on Line 30 of Worksheet E, Part A. In contrast, the version of the cost reported used for FY 2011 is the form CMS-2552-10 in which NAH Part C payments were reported on Line 53 of Worksheet E, Part A, as relevant, and any protested amounts were reported on Line 75 of Worksheet E, Part A.

[78] Stip. at ¶¶ 1.4.2, 2.1.9 (Case Nos. 16-2290, 17-0907).

[79] This is the cost report instruction for Line 53 of Worksheet E, Part A on the form CMS-2552-10, used for FY 2011 and after. Similar instruction existed for Line 11.01 of Worksheet E, Part A for the form CMS-2552-96, used for FY 2010.

> Total [Part C] inpatient days for that same cost reporting period. (If applicable, ***obtain*** *the number of [Part C] inpatient days from the Provider Statistics and Reimbursement Report (PS&R), report type 118*. [Part C] encounter days associated with providers and units excluded from the IPPS issued by CMS may be added to the inpatient days from report type 118.[80]

PM A-03-043 clearly states Medicare contractors are to *obtain* the number of Part C inpatient days from the PS&R report type 118. The PS&R system accumulates statistical and reimbursement data based on claims submitted by providers on the form CMS-1450 (also previously known as UB-92 and currently known as the UB-04[81]). Along with the PS&R Summary Report, the Medicare Contractor uses the standard Remittance Advice ("RA") which explains the reimbursement claim decisions including the reasons for payments and adjustments of processed claims. Hospitals that operated an NAH program were instructed to submit the Part C Managed Care claims as a no-pay bill using the form CMS-1450 with condition codes 04 ***and*** 69 so that the Part C inpatient days could be accumulated on the PS&R (report type 118) to calculate the Part C NAH payment on the cost report.[82]

On May 23, 2003, PM A-03-043 was issued to provide further clarification regarding the calculation of the NAH payment and, in that Program Memorandum, Medicare contractors were instructed to obtain the data from the PS&R report type 118. However, Bon Secours failed to use condition code "69" to designate the no-pay bill as one for a teaching hospital and rather only used condition code 04 to note it was an information-only bill (*i.e.*, no-pay or shadow bill).[83] The absence of condition code "69"on Bon Secours' no-pay bills caused the NAH Managed Care Part C days at issue to be omitted from Bon Secours' PS&R report type 118 because both condition codes 04 and 69 were required in order to make it to this PS&R report type.[84] The Medicare Contractor relied on Bon Secours' PS&R report type 118, and the cost reports at issue, to calculate the Part C days for Bon Secours' Part C NAH payments for FYs 2010 through 2013.[85]

Bon Secours contends that "the PS&R report 118 is erroneous and that the [Medicare Contractor] is *required* to use other auditable data to accurately calculate the Provider's [Part C] Medicare Managed Care Days for NAH payment."[86] Bon Secours claims it "has supplied examples of its shadow billing and corresponding remittance from the [Medicare Contractor] that demonstrates [Bon Secours'] practice of shadow billing for its Medicare Managed Care days."[87] Bon Secours also cites to previous Board decisions which permit the Medicare Contractor's use of the PS&R report "unless the provider furnishes proof that inaccuracies exist"[88] and argues that the Board has previously held that the PS&R data is not always the best evidence available and may be

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[80] (Italics and bold emphasis added, and underline emphasis in original.)
[81] *See supra* note 46.
[82] Medicare Contractor's FPP at 4 (Case No. 15-2971).
[83] Stip. at ¶ 2.8 (Case No. 15-2971).
[84] Stip. at ¶ 2.9 (Case No. 15-2971).
[85] Stip. at ¶ 2.10 (Case No. 15-2971).
[86] Provider's FPP at 7 (Case No. 15-2971) (emphasis added).
[87] *Id.* at 9.
[88] Provider's FPP at 8 (citing to CMS Pub. 13 § 2242 (2012) and *Research Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2012-D12 (Mar. 9, 2012)).

disputed with contrary evidence.[89] Additionally, it notes that, in the past, the Board "held that the failure to capture a provider's Medicare Managed Care data being on the PS&R report was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[90]

However, the Board finds that, in these cases and under the circumstances, the Medicare Contractor did use the best available data by relying on the PS&R Report type 118 for determining Bon Secours' NAH payment for each respective fiscal year. The preamble to the 1998 Final Rule, as well as PMs A-98-21 and A-03-007, all plainly instruct teaching hospitals (including Bon Secours) to bill claims for Part C enrollees using condition codes 04 ***and*** 69. As conceded in the Parties' Stipulations at ¶¶ 2.8 & 2.9,[91] Bon Secours did not submit no-pay bills in a UB-92 format using the condition code 69, until some point during or after its FY 2010, *for discharges in its FY 2010*, to designate the bill as one for a teaching hospital. As a result, (as made clear in PM A-03-007), the Part C days at issue were omitted from the PS&R report type 118 and were not reconciled on the cost reports at issue. Bon Secours had ample notice to properly bill the claims in accordance with the PM A-03-007 and, per PM A-03-043, knew the Medicare Contractor would base the NAH Part C payment on the PS&R report type 118. Moreover, Bon Secours could have sought a correction of the Part C days, through a reopening of the cost report, but failed to make the request of the Medicare Contractor.

Bon Secours' argument that the no-pay bills associated with the Part C days at issue were not reflected on the PS&R Type 118 "[f]or reasons unknown and beyond the Provider's control"[92] rings hollow. Provider's Exhibit P-4 (Case No. 15-3228) addresses the calculation from PM A-03-043, which was used to develop the Bon Secours' protested amount, filed on the FY 2011 cost report. The Exhibit states: "Note: this calculation is specified for calendar year 2001. CMS has not issued any further instructions at this point in time."[93] Yet, Program Memorandum A-03-043 was published on May 23, 2003. On February 3, 2003, (three months prior), CMS published PM A-03-007, which states in pertinent part:

> [T]his transmittal modifies Transmittal A-98-21 to permit these non-IPPS hospitals and units to submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.
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> ****
>
> [T]his transmittal also applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their M+C enrollees under 42 CFR 413.87(e).

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[89] Provider's FPP at 9 (citing to *Campbell's Provider Care, Inc. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. 2001-D22 (May 2, 2001)) (Case No. 15-2971).
[90] *Id.* (citing to *Santa Barbara Cottage Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. 2007-D78).
[91] Case No. 15-2971.
[92] Provider's FPP at 1 (Case No. 15-2971).
[93] Ex. P-4 at 1 (Case No. 15-3228).

> These providers would similarly submit their M+C claims to their respective intermediaries to be processed as no-pay bills ***so that the M+C inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the M+C N&AH payment through the cost report.*** (The instructions for calculating this payment will be explained in a separate transmittal).
>
> …. hospitals that operate an approved N&AH program ***must*** *submit claims* to their regular intermediary in UB-92 format, *with condition codes 04* ***and*** *69 present* on record type 41, fields 4-13, (Form Locator 24-30). ***Condition code 69*** has recently been modified by the National Uniform Billing Committee to indicate that the claims, in addition to being submitted for operating IME and DGME payments to IPPS hospitals may now be submitted as *no-pay bills … for purposes of calculating* the DGME and/or ***N&AH payment*** *through the cost report*.
>
> ****
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> Provider Education
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> [Medicare contractors] must notify, through their Web sites and their next regularly scheduled bulletins, all hospitals that either operate only GME program(s), only N&AH education program(s), or operate both GME and N&AH education programs, within 30 business days after receipt of the electronic copy of this PM of the above reporting requirements. Electronic billing associations and clearinghouses must be notified within 30 business days as well. Include the following information in this notice:
>
> Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) ***must*** *submit separate bills for payment for M+C enrollees*. The M+C inpatient days are to be recorded on PS&R report type 118. For services provided to M+C enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their intermediary for these cases in accordance with the instructions otherwise described in this transmittal. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report M+C inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

Thus, *prior to the Program Memorandum to which Bon Secours has cited,* CMS had already issued instructions specifying that claims must be billed with Code 69 to be reported on the PS&R

report type 118 for NAH payment calculation purposes. Similarly, Medicare contractors were to notify providers with NAH programs of this new requirement. The May 2003 Program Memorandum is the "separate transmittal" referred to in PM A-03-043 as the instructions for calculating the NAH payment. Bon Secours billed no FY 2008 or 2009 Part C claims with condition code 69, resulting in 0 days being reported on the PS&R report type 118s in those years.[94] This fact is undisputed by the parties (as reflected in their stipulations). Beginning September 1, 2010, through August 31, 2011, a portion of Bon Secours' Part C inpatient days were properly billed using condition code 69.[95] Thus, Bon Secours finally began billing its days using condition code 69 during, or shortly after, 2010, a full *seven years after* CMS issued *PM A-03-007*, which required that code 69 must be used on bills to properly reflect the claims on PS&R report type 118. The word "must" in that Program Memorandum is not "suggestive" or "permissive," but a requirement.

Bon Secours' citation to PRRB Dec. 2007-D78 argues that the Board found that "the PS&R was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[96] However, Bon Secours fails to mention that the Administrator reviewed and reversed the Board's decision on this issue.[97] The Board also notes that the cases in that 2007 decision related to DGME (as opposed to NAH) for cost reports/appeals for 1998 through 2001. Similarly, the other PRRB Decision cited by Bon Secours (PRRB Dec. 2001-D22) related to a home health agency and its cost reporting period ended December 31, 1995. Notably, these cases involve cost reporting periods that took place *prior to* the issuance of PM A-03-007 in February 2003, which confirmed that NAH programs must submit no-pay bills for Part C days using condition codes 04 ***and*** 69. The instructions in the Program Memorandum make clear that claims made after the effective date must be billed with condition codes 04 and 69 for purposes of calculating any additional NAH payment. Finally, unlike DGME, PM A-03-043 makes clear that the additional Part C payments are made from a defined pool that is divided between all qualifying NAH providers and, as a result, a NAH provider's PS&R report type 118 is used not just relative to that NAH provider's payment but also relative to payment for all other NAH providers. Accordingly, the Board finds that these Decisions are distinguishable and do not provide support for Bon Secours' contentions.

Finally, 42 C.F.R. § 413.87(e), as quoted above, indicates that the additional payment for NAH, related to Part C patients/days, is calculated at a national level. CMS is using managed care payments, total inpatient days, and Part C days "for **all** eligible hospitals"[98] to determine each hospital's ratio of the payment pool, which "may not exceed $60 million in any calendar year."[99] Bon Secours' failure to bill the days with the condition code 69, so that those days would be properly reported on PS&R report type 118, not only affects Bons Secours, but ***all*** NAH providers participating in the calculation. Allowing additional days to be included only for Bons Secours, when they were not properly billed, would affect all NAH providers negatively, even though those providers did bill their days correctly. The issue is not simply that the days can be

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[94] Ex. P-6 (Case No. 16-2290).
[95] Ex. C-7 (Case No. 17-0907).
[96] Provider's FPP at 9 (Case No. 15-2971).
[97] *Santa Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n,* Adm'r Dec., *reversing* PRRB Dec. 2007-D78. The Board also notes that PRRB Dec. 2007-D78 was not a unanimous decision.
[98] 42 C.F.R. § 413.87(e)(3).
[99] 42 C.F.R. § 413.87(f)(3).

proven to have been billed, albeit incorrectly, but also that it alters the payment calculation and pool for the *entire* community of NAH hospitals. Thus, CMS' reliance upon PS&R report type 118 for all providers, in terms of Part C days, is both consistent and proper, as the providers have been notified that these claims must be billed with codes 04 and 69 for this very purpose. There is nothing in the record of these cases that demonstrates that Bon Secours was not able to, or somehow prevented from, correctly billing the days at issue; thus, the years of incorrect billing was not "beyond the Provider's control. . . ."[100] Rather, Bon Secours failed to bill in the proper fashion until some point during or after its FY 2010, *for discharges in its FY 2010*, which was ***over seven years*** after billing instructions were issued by CMS.[101]

As further evidence that the failure to bill was not beyond its control, Bon Secours has corrected this error in years subsequent to those at issue herein.[102] This could have been corrected, within the one-year billing requirements, at any time. Bon Secours did not do so until 2010. Bon Secours is responsible for their actions, *and* the detrimental results of those actions.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly adjusted Bon Secours' NAH Part C Managed Care payment for FYs 2010 through 2013 to exclude the Medicare Part C data associated with the no-pay bills at issue.

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For the Board:

9/15/2023

X Clayton J. Nix

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

[100] Provider's FPP at 1 (Case No. 15-2971).
[101] It also raises questions about what Bon Secours did in fiscal years prior to the ones at issue here. Were they billing properly in earlier years but stopped doing so around the beginning of calendar year 2008?
[102] *See* Ex. C-7 (copy of the PS&R report type 118).