PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D3

PROVIDER -
Bayfront Medical Center
St. Petersburg, FL

Provider No.: 10-0032

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Service Options, Inc.

DATE OF HEARING -
January 11, 2007

Cost Reporting Periods Ended -
June 30, 1998; June 30, 1999 and
December 31, 1999

CASE NOs.: 01-2270; 02-1573
and 03-1015

INDEX

ISSUES:

1. Whether the Intermediary improperly disallowed direct graduate medical education (DGME) and indirect medical education (IME) payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal years ending June 30, 1998, June 30, 1999, and December 31, 1999.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Section 1886(h) of the Social Security Act (Act) prescribes the Medicare payment method for direct GME costs. 42 U.S.C 1395ww(h). In brief, the direct GME payment is the product of a hospital's average per resident amount, derived and updated from a 1984 base period, times the hospital's number of interns and residents in approved GME programs during the payment year, times the hospital's Medicare patient load.

The Act at section 1886(d)(5)(B) provides that teaching hospitals that have residents in approved GME programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. Regulations at 42 C.F.R. §412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is based on the indirect teaching adjustment factor, calculated using the hospital's ratio of full-time equivalent (FTE) residents to beds.

Prior to the enactment of the Balanced Budget Act of 1997 (BBA '97), the numerator of the Medicare patient load fraction included only the number of patient days attributable to the Medicare beneficiaries who were entitled to have payment made under the Medicare Part A fee-for-service program. CMS did not include inpatient days attributable to enrollees in Medicare risk plans (i.e., Medicare Health Maintenance Organizations (HMOs) or Competitive Medical Plans (CMPs) with risk sharing contracts under section 1876 of the Act). In 1989, when CMS promulgated the regulations implementing the prospective payment method for GME, the agency determined that these Medicare managed care plan days would not be counted as Medicare days in the Medicare patient load used to calculate Medicare payment for GME.[1]

Section 4624 of BBA '97 amended the DGME statute by adding a new provision in section 1395ww(h)(3)(D) for an additional GME payment with respect to patient days attributable to services furnished to Medicare beneficiaries enrolled in a Medicare + Choice plan or any other Medicare managed care plan with a risk sharing contract under section 1876 of the Act. The regulations implementing this provision were codified at 42 C.F.R. §413.86. Similarly, BBA '97 amended the IME statute by adding a new provision in 42 U.S.C. §1395ww(d)(5)(B). The regulations implementing this provision are set forth in 42 C.F.R. §412.105(g).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Bayfront Medical Center (Provider) is a Medicare certified teaching hospital located in St. Petersburg, Florida. For each of the years under appeal, First Coast Service Options, Inc. (Intermediary) issued NPRs adjusting the Provider's IME and DGME payments for Medicare beneficiaries enrolled in Medicare risk plans. With the exception of the Provider's June 30, 1998 fiscal year, the Intermediary made adjustments to the cost report settlement data to match the statistics reflected on the Provider Statistical and Reimbursement Report (PS&R). The PS&R for each fiscal year in question did not include all of the statistics for discharges the Provider claimed for beneficiaries enrolled in Medicare risk plans.

During the Provider's 6/30/98 fiscal year audit, the Provider furnished to the Intermediary its supporting logs that identified all days of care rendered to Medicare risk plan patients. For DGME, the Intermediary accepted the 508 days listed on the PS&R and added an additional 3,873 days that were included on the Provider's logs but not on the PS&R, for total of 4,381 days. However, the Intermediary did not allow 1,459 days of care reflected in the Provider's log. For IME, the Intermediary adjusted directly to the PS&R and did not consider the Provider's records. During the audits of the Provider's 6/30/99 and 12/31/99 fiscal ears, the Intermediary made adjustments for both DGME and IME payments, adjusting directly to the PS&R and did not consider the Provider's records.

At issue is whether the Intermediary improperly disallowed the discharges that were not reflected in the PS&R.

[1] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989).

The Provider appealed the disallowance to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835 - 405.1841. The Provider is represented by Joanne B. Erde, P.A., of Duane Morris, L.L.P. The Intermediary is represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider argues that the Intermediary improperly adjusted the settlement data used to determine DGME and IME payments with respect to Medicare + Choice beneficiaries in its cost reports. The Provider asserts that changes enacted in BBA '97 allowed the Provider to receive additional DGME and IME payments for hospital inpatients enrolled in Medicare + Choice or other Medicare risk plans. Nothing in the statute or Office of Management and Budget (OMB) standards required the Provider to submit data directly to the Intermediary within a specified time. The Provider claims that the Medicare risk plans submitted UB-92 data relating to Medicare risk plan discharges to the Intermediary before the audits for each of the fiscal years at issue were completed and the Intermediary did not include that data in the settled cost reports. Moreover, the Provider asserts that it also provided the encounter data, in UB-92 format, relating to Medicare risk plan discharges to the Intermediary before the audits for each of the fiscal years at issue were completed, and the Intermediary improperly rejected and excluded the data in the settled cost reports.

The Intermediary argues that it was the Provider's responsibility to file a timely UB-92 claim form to the Intermediary through the claims processing system in order to obtain IME and DGME payment for managed care enrollees. The Intermediary argues that Program Memorandum (PM) A-98-21 was issued on July 1, 1998 to address the BBA provision. The PM instructed intermediaries as follows:

> This Program Memorandum outlines intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Section 4622 and 4624 of the Balanced Budget Act of 1997 states that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees. . .

The PM goes on to say:

> PPS hospitals must submit a claim to the hospitals' 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 is a new code recently approved by the National Uniform Billing Committee to indicate that the claim is being submitted for operating IME payment only.

The Intermediary argues that the PM issued by CMS made clear that the Provider was required to bill its Intermediary if it wanted to receive IME and DGME payments for its Medicare managed care enrollees.

Consistent with the Intermediary's position that the Provider had to submit a claim to the Intermediary to receive IME/DGME payments for the Medicare + Choice beneficiaries, the Intermediary argues that the Provider's claims had to be timely submitted to the Intermediary as required by the timely filing standards. Those standards are defined in 42 C.F.R. §424.44:

(a) Basic limits. Except as provided in paragraph (b) of this section, the claim must be mailed or delivered to the intermediary or carrier, as appropriate-
(1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and
(2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.
(b) Extension of filing time because of error or misrepresentation.
(1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.
(2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

The Intermediary argues that since the Provider did not file the UB-92 claims with the Intermediary until after the filing deadline for the claims, the hard copy submission of these claims to the Intermediary for its review and inclusion in the cost report was insufficient to cure the Provider's failure to bill. The Intermediary asserts that since the Provider did not properly bill the claims, the claims were properly rejected and not included in the final settled cost reports.

The Provider argues that the Intermediary's assertion that the DGME and IME payments should be denied because the Provider did not submit the claims within the time period allowed for submission of Medicare claims for payment is unsustainable. The Provider asserts that no law required the Provider to submit this data directly to the Intermediary within a specified time period. The guidance and instructions issued by CMS and the Intermediary subsequent to BBA '97 include:

- December 24, 1997 – CMS issued an Operational Policy Letter (OPL No. 64) outlining a draft process for submission of hospital encounter data.
- May 19, 1998 – CMS issued an "Operational Policy Letter" (OPL No. 70) drafting a list of language requirements for plans for data submission.
- June 26, 1998 - 42 C.F.R. §422.257 was issued requiring that "each M + C organization must submit to CMS (in accordance with CMS instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician or other practitioner."

- July 1, 1998 – PM A-98-21 was issued to intermediaries. This PM directed intermediaries to notify providers of the following: "Teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME."
- August 6, 1998 – Medicare Part A – Hospital Medicare Bulletin H-90 was issued by the Intermediary (Exhibit I-2). The subject line of the Bulletin read: "Payment to Hospitals for Direct Costs of Graduate Medical Education (DGME) and Operating Indirect Medical Education (IME) Costs for Medicare + Choice Enrollees." The first paragraph of the Bulletin stated:

> The purpose of this bulletin is to outline intermediary and standard system changes needed to process requests for IME and DGME supplemental payments for Medicare managed care enrollees. Section 4622 and 4624 of Balanced Budget Act (BBA) of 1997 state that hospitals may now request a supplemental payment for operating IME for Medicare managed care enrollees. During the period from January 1, 1998 through December 31, 1998, provider will receive 20 percent of the fee for service DGME and operating IME payment. This amount will increase 20 percent each consecutive year until it reaches 100 percent.

While the Bulletin advised providers of availability of additional DGME and IME reimbursement, DGME was discussed only in its first paragraph.

- June 29, 2000 – CMS published the final rule for Medicare + Choice program (65 Fed. Reg 40170) in response to comments regarding the June 1998 interim final rule. CMS acknowledged a "range of problems in the submission of encounter data . . ." including intermediary processing problems and confusion regarding hospital submission of encounter data. This final rule established a retrospective reconciliation process for encounter data.
- February 3, 2003 – Program Memorandum A-03-007 was issued acknowledging that the early July 1998 PM did not address GME payments for non-IPPS hospitals and units. The February 2003 memorandum states that these hospitals and units "must submit claims to their regular intermediary in UB-92 format" to obtain GME payments, but this was made effective prospectively beginning July 1, 2003.

The Provider asserts that it was not until the February 3, 2003 PM was issued, well after the current years in question that the term"must bill" was used to describe how providers could receive DGME and IME payments for the managed care enrollees. CMS also did not directly inform the providers that the bills had to be submitted to the intermediaries (instead of the managed care plans) in order for hospitals to obtain the DGME and IME payments. In addition, CMS failed to instruct the intermediaries to give proper notice to the hospitals on how these bills were to be submitted (i.e., electronically or in paper format) or the time frame in which to submit them.

In addition, the Provider argues that the Medicare regulation governing the requirements and time period for submission of Medicare claims for payment expressly do not apply with respect to services furnished to enrollees in Medicare risk plans. 42 C.F.R. §424.30. Therefore, CMS provided no guidance as to a time frame in which these claims had to be submitted.

Finally, the Provider argues that it cannot be penalized for having failed to meet a requirement to submit claims directly to the Intermediary in order for it to obtain the IME and DGME payments, as no such requirement was ever approved by the OMB. The Provider asserts that the federal Paperwork Reduction Act would preclude CMS from applying such a requirement to deny the Provider the benefit of the DGME an IME payments at issue without obtaining OMB approval for the data collection. See, 44 U.S.C. §3512(a).

The Intermediary avers that the managed care plans were under an obligation to file encounter data long before the issuance of BBA '97; therefore, the filing of these claims was not a new requirement that would have needed special approval.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

The Balanced Budget Act of 1997 (BBA' 97) provided for IME and DGME payments for services provided under risk HMO contracts that, prior to the BBA, had not been available. The Secretary was given broad authority to provide for or devise a way to pay hospitals supplemental payments for DGME and IME. 1395ww(h)(3)(D) entitled Payment for managed care enrollees states:

> (i) In general. For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1395mm of this title and who are entitled to part A of this subchapter or with a Medicare + Choice organization under part C of this subchapter.

1395ww(d)(11) entitled Additional payments for managed care enrollees states:

> (A) In general.— For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

The question before the Board is what conditions precedent must be satisfied to entitle a hospital to payment for the new additional benefit.

The Board majority finds that this dispute is governed by the regulation, 42 C.F.R. 424.30 et seq. Prior to the BBA' 97, whether a "claim" (described elsewhere as a form UB92) filed for each patient stay was required was governed by 42 C.F.R. § 424.30 which states:

> This subpart sets forth the requirements, procedures, and time limits for claiming Medicare payments. Claims must be filed in all cases except when services are furnished on a prepaid capitation basis by [HMOs].

42 C.F.R. §424.32 et. seq. furnishes more detail including the "basic requirements" for filing all claims including the requirement that the claim be filed with the hospital's intermediary and within the time limits specified in section 424.44.

Therefore, prior to BBA' 97, in order to receive payment for the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with Medicare intermediary. But if the beneficiary was a member of a risk HMO which had been prepaid by Medicare, the hospital filed its claim for payment for services furnished with the HMO, not the intermediary. The claims in question, for services furnished by and paid for by Medicare + Choice organizations or other Medicare risk plans, are specifically exempt from the requirements, procedures and time limits under this section. The information that would be needed to process these claims by intermediaries is contingent upon the Medicare HMO plans' payment processing methods which are entirely disparate from the fee-for-service plan.

In addition, prior to the BBA' 97, despite the process for filing claims for payment for *services furnished*, hospitals were nevertheless required by the hospital manual to file 'no pay' bills for tracking or utilization purposes only, for example, to set capitated rates. These were referred to as 'no-pay' bills and the data assembled was referred to as 'encounter data.'

> A. No-Payment Situations Where Bills Must be Submitted.-- Situations for which bills are required include the following. If part of the admission will be paid and part not, prepare one bill covering the entire stay . . .
>
> * * * *
>
> For services provided to an HMO enrollee for which an HMO has jurisdiction for payment. Since HCFA is instructing you to provide this information, negotiate an agreement with the HMO for submitting to it bills it pays. Include in your agreement with HMOs a clear statement of

> the data elements required for proper identification of Medicare HMO/CMP enrollees and accurate submission to the intermediary.
>
> Where the HMO does not have jurisdiction, prepare a payment bill.

CMS Program Manuals - Hospital (PUB. 10), Chapter IV - Billing Procedures 411. Submitting Inpatient Bills In No-Payment Situations.

The BBA' 97 and the Secretary's implementing regulations clearly shifted the burden for filing encounter data squarely to the risk HMOs.

> In order to carry out this paragraph, the Secretary shall require Medicare + Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

42 U.S.C. §1395w-23(a)(3)(B).

> Data collection: Basic rule. Each M+C organization must submit to CMS (in accordance with CMS instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

42 C.F.R. §422.257(a) (interim final rule was published in June 1998). No changes were made to 42 C.F.R. §424.30, however. Furthermore, neither the regulatory changes implementing the new IME/DGME payment nor any other regulation gave notice that hospitals would now be required to file a separate IME/DGME claim with the intermediary that was virtually identical to the claim filed with the HMO to recover payment for inpatient services.

When 42 C.F.R. §424.30 governing claims filing was implemented, there was no contemplation of or any need for a "claim for payment" other than the claim to obtain payment for the inpatient *services furnished* to the beneficiary. When the additional payment for IME/DGME was authorized by the BBA' 97, it did not change the nature of the payment for "services furnished." Rather, the IME/DGME payment arises from "services . . . furnished on a . . . capitation basis . . ." for which filing a claim *with the intermediary* is excepted under 42 C.F.R. § 424.30.

The Secretary has been given extremely broad authority to implement procedures for payment. However, once the system was established by regulation linking the obligation to file an intermediary claim with the method of payment, CMS' effort to impose a contrary claims filing requirement via guidance in an Administrative Bulletin is insufficient to deprive a provider of its statutory right to payment. The Administrative Bulletin issued by the Intermediary on August 6, 1998 states that "teaching hospitals may submit bills for inpatient stays by managed care enrollees for payment of IME". This bulletin only addressed 'IME cost' payments and did not specify a definite date when this billing should begin or make any reference to PM A-98-21 for further guidance.

Nowhere does the Board majority find a directive to the Provider that states that in order to receive IME and DGME supplemental payments provider ***must*** bill the Intermediary. The Administrative Bulletin simply states that you 'may' bill.

Despite the fact that CMS had a very short timeframe to implement the provisions of BBA' 97, specifically, for the issue in question by the effective date of 1/1/98, CMS should have followed the Administrative Procedures Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from 1/1/98 until the finalization of the rule. If the regulatory obligation to file a "claim" is to be bifurcated so that a provider has an obligation to file its claim for payment of services to the beneficiary with the HMO and to also file a virtually identical claim to the intermediary, then the Board majority believes that a regulatory notice is required.

The Intermediary does not dispute that the Provider complied with requirements for timely filing its claims for payment for inpatient services with the HMO and, in fact, the Provider seeks to rely on those records as proof of entitlement and for calculation of its IME/DGME additional payment claimed (in the generic sense) via its cost report. The expense of graduate medical education that the hospital incurred in providing services furnished on a capitation basis is only one element of many costs properly reported and claimed on the cost report. The data contained in those claims to the HMOs along with the remittance advices reflecting payment is proper evidence and must be considered by the Intermediary to determine the IME/DGME payments due the Provider.

Furthermore, for the period from 1/1/98 up until the date of notice, the option to bill and receive an interim payment was not available, and the use of an alternate method was necessary to allow providers to make a request (or claim) for these payments. For this reason, the Board majority finds that the Intermediary's disallowance of the subject days, based on the fact that the Provider did not bill and the data was not captured on the PS&R, is without basis. The Provider furnished to the Intermediary a detailed log of the Medicare managed care enrollees it serviced during the periods at issue from its records for verification and inclusion in the Medicare cost report. The Intermediary's refusal to audit the data made available to support the Provider's claim was a misuse of its discretion and the case must be remanded to Intermediary to complete the audit.

DECISION AND ORDER:

The Intermediary improperly disallowed DGME and IME payments with respect to discharges of Medicare beneficiaries who were enrolled in the Medicare + Choice or other Medicare risk plans in fiscal year periods ending June 30, 1998, June 30, 1999, and December 31, 1999. The Intermediary's adjustments are reversed and the cost reports are remanded to the Intermediary to include the days applicable to the Medicare + Choice enrollees.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A. (Dissenting)
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes

DATE: October 12, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

Dissenting Opinion of Elaine Crews Powell

The majority found that the Intermediary improperly excluded some of the Provider's Medicare managed care days from the calculation of the Provider's additional IME and GME reimbursement authorized by sections 4622 and 4624 of the BBA of 1997. I respectfully disagree.

Fundamentally, I find that Transmittal No. A-98-21 was an appropriate means by which to implement program payments provided for in the applicable IME and GME statutes and regulations. I also find that the requisite claims for the additional reimbursement were not exempt from submission to the Intermediary pursuant to 42 C.F.R. §424.30 and that these claims were not for services "furnished on a prepaid capitation basis by a health maintenance organization…" as envisioned by that section. Rather, the claims were "claims for payment" for the additional IME and GME reimbursement due the Provider because of its medical education activities, and thus, they were subject to the timely filing requirements of 42 C.F.R. §424.44.

CMS is responsible for ensuring proper program payments to providers who furnish services to Medicare beneficiaries. Under its broad authority to accomplish this mandate, CMS employs various vehicles and prescribes various processes. These include the issuance of regulations and manual instructions as well as program memorandums and transmittals. CMS notified intermediaries and the public regarding the availability of the additional reimbursement for Medicare managed care enrollees when it formally modified the IME and GME regulations on August 29, 1997 (62 Fed. Reg. No. 168). CMS' publication of Transmittal A-98-21 instructed intermediaries to notify their hospitals of the right to request the additional payments and the means by which the payments could be secured. Contrary to the Board majority's opinion, I find that there was no need for CMS to publish a new regulation with the required notice and comment period. CMS clearly intended to get the additional reimbursement to teaching hospitals as soon as possible, and I find that the use of a transmittal was a well established, efficient way to do so. Intermediaries have processes in place to manage the receipt of information and instructions from CMS and for the dissemination of that information to their affected providers. I find that this Intermediary followed those procedures.

The fact that the Provider actually filed UB-92 claim forms for many of its Medicare Managed care patients during each of the three fiscal periods in issue is clear evidence that it knew of the requirement to bill for the additional IME and GME reimbursement and that it attempted to do so.[2] The Provider's position paper discusses the systems problems it experienced in filing claims for all of its M + C patients.[3] However, what is not clear from the record in this case is why the Provider did not follow up when the billed claims did not process as expected. While the Provider argues that the

[2] See, Provider's Position Paper, pages 4-6.
[3] Id. pg. 7.

Intermediary did not furnish it a remittance advice (RA) for the claims that could not be processed, it is my understanding that an RA is not generated unless a claim is accepted for processing by the claims system. Electronic claims that cannot be processed are "returned to the provider" (RTP'd) on an RTP report, and the provider is given 60 days for follow-up. If the claims are not addressed within that timeframe, it is as though the claims were never filed because the RTP'd claims are purged. Accordingly, if the electronically filed UB-92 claim forms for the Medicare managed care enrollees did not contain the data required for the claims processing system to accept the claims, and the Provider did not follow-up on RTP'd claims, no RA would have been expected to be generated. In my opinion, the Provider is clearly responsible for following up on its claims and for resolving any problems that prevented those claims from processing.

The Provider ignored the Program's claims filing requirement to its detriment, and its numerous arguments are, at bottom, aimed at shifting the burden for ensuring accurate IME and GME payment to the Intermediary. I find that the Provider was responsible for claiming all the reimbursement to which it was entitled and that it received timely notification of the manner in which that reimbursement was to be claimed.

The Intermediary's refusal to accept the Provider's logs and compute the additional IME and GME reimbursement through the cost report was proper.

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Elaine Crews Powell, CPA