PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D17

PROVIDER –
Sparrow Health 98-99 IME Managed Care Group

Provider Nos.: Various
(See Attached Schedule of Providers)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services

DATE OF HEARING –
August 25, 2005

Cost Reporting Periods Ended -
December 31, 1998 and December 31, 1999

CASE NO.: 04-0088G

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ISSUE:

Whether the Providers are entitled to receive additional indirect medical education (IME) and direct graduate medical education (DGME) payments for Medicare managed care enrollees for fiscal years ended December 31, 1998 and 1999.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative 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.

This case involves Medicare share of costs for medical education.

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 bed.

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. §413.105(g).

In addition, CMS issued Program Memorandum, HCFA Pub. 60A (Transmittal No. A-98-21), dated July 1, 1998, to its intermediaries. In part, the memorandum explained that hospitals could request the supplemental medical education payments; that hospitals would need to submit specifically coded Medicare claims (in UB-92 form) to receive the payments; and, that intermediaries were to notify their providers, electronic billing associations, and clearinghouses of the reporting requirement within three business days after receipt of the electronic copy of the Program Memorandum.[2]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

E.W. Sparrow Hospital and St. Lawrence Mercy Hospital (Providers) are short-term, acute care teaching hospitals located in Lansing, Michigan. As teaching hospitals with approved medical education training programs, the Providers appropriately claim reimbursement for costs associated with both IME and DGME. Health Care Service Corporation (Intermediary)[3] reviewed E.W. Sparrow Hospital's cost reports for its fiscal years ended December 31, 1998 and 1999, and St. Lawrence Mercy Hospital's cost report for its fiscal year ended December 31, 1998. As part of these reviews, the Intermediary adjusted the Providers' Medicare settlement data statistics (patient days, discharges, interim payments, etc.) to agree with data captured in the Provider Statistical and Reimbursement Report (PS&R). However, the Providers concluded that the PS&R did not include data all of their Medicare managed care enrollees and that their Medicare reimbursement for IME and DGME was, therefore, understated. According to the

[1] 54 Fed. Reg. 40286, 40294-95 (Sept. 29, 1989).
[2] Exhibit I-3.
[3] United Government Services subsequently replaced the Health Care Service Corporation as the Providers' intermediary.

Providers, the PS&R did not include the data for all Medicare managed care enrollees because they had not submitted the specifically coded UB-92 billing forms required by Program Memorandum (PM) A-98-21 on a timely basis, and the Intermediary rejected their request to accept a late filing of those bills.[4]

The Providers appealed the Intermediary's Medicare settlement data adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841. The amount of Medicare funds in controversy is approximately $527,000.

The Providers were represented by Kenneth R. Marcus, Esq. of Honigman, Miller , Schwartx and Cohn, LLP. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that the Intermediary failed to notify them of the reporting requirements contained in PM A-98-21; therefore, they did not submit the requisite UB-92s and the PS&R did not reflect data for all of the Medicare managed care enrollees. The Providers also contend that the UB-92 filing requirement is not supported by the enabling statutes or by regulation. However, all of the information necessary for the Intermediary to reimburse the Providers the IME and DGME amounts to which they are entitled is available. In addition, the Providers assert that even if the Intermediary's claims processing system cannot accept the UB-92s that are beyond the claims timeliness requirements of 42 C.F.R. §424.44, the UB-92 payment calculation can be simulated.[5]

The Intermediary contends that it maintained a process to advise its providers of the program memorandum's requirements, and that it was unaware of complaints by any other hospitals it serviced that they had not been advised of the UB-92 reporting requirement. The Intermediary's witness testified that because the Providers were in the process of merging their operations in 1998, that they elected not to submit the Medicare managed care UB-92s due to other priorities.[6] The Intermediary also contends that it is not possible to accurately simulate the DRG payment calculation. The DRG payment determination is made through the Intermediary's claims processing system, and because this system is updated every year, the payment information applicable to the subject cost reporting periods, specifically the PRICER, are no longer maintained or available in the system.[7]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes as follows:

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[4] Transcript (Tr.) at 21.
[5] Providers' Supplemental Position Paper at 6. Providers' Post Hearing Brief at 15.
[6] Tr. at 58-59.
[7] Tr. at 72-74.

The Providers in this case, St. Lawrence Mercy Hospital and E.W. Sparrow Hospital, essentially challenge the number of patient days and discharges used by the Intermediary to determine the additional DGME and IME reimbursement they could receive pursuant to sections 4622 and 4624 of the Balanced Budget Act of 1997. The Board finds that it does not have jurisdiction over St. Lawrence Mercy Hospital's challenge and it is, therefore, dismissed from the case. Regarding E.W. Sparrow Hospital, the Board majority finds that the Intermediary used the incorrect number of Medicare managed care discharges/patient days to determine the Provider's additional IME and DGME reimbursement.

Upon review of the Providers' cost reports, the Board finds that St. Lawrence Mercy Hospital had not claimed any Medicare managed care discharges/patient days in its 1998 cost report nor did it claim additional reimbursement for IME and DGME pursuant to the BBA '97 (See, Form CMS-2552-96, Worksheet S-3, Part I, Line 2, and Worksheet E, Part A, Lines 1.03-1.05). Moreover, a review of its audited and final settled 1998 cost report shows that the Intermediary made no adjustments to these statistics. Therefore, the Board does have jurisdiction over St. Lawrence Mercy Hospital's 1998 cost report pursuant to 42 U.S.C. 1395oo and 42 C.F.R. §405.1835. Except in limited circumstances not relevant here,[8] these authorities contemplate that a final determination be made by an intermediary as a prerequisite to Board jurisdiction. Here, the Intermediary made no such determination with respect to the Medicare managed care discharges/patient days because the hospital did not claim reimbursement for all costs to which it is entitled to be reimbursed. Therefore the hospital cannot, on appeal to the Board, first ask for new costs. Little Company of Mary Hospital Health Care Centers v. Shalala, 24 F.3d 984 (7th Cir. 1994).[9]

With respect to E.W. Sparrow Hospital, the Board majority finds that the Provider also did not claim Medicare managed care discharges/patient days in the cost reporting periods at issue nor did it claim additional IME and DGME reimbursement pursuant to the BBA '97. However, the Intermediary did adjust (increase) the Provider's Medicare managed care statistics and the IME and DGME reimbursement pursuant to the BBA '97. Accordingly, final determinations with respect to Medicare managed care days and discharges, although positive in nature with respect to the Provider's program payments, were rendered by the Intermediary thereby meeting the jurisdictional requirements of the regulations.

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[8] See, e.g. Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988).

[9] The Board acknowledges the Provider's argument that jurisdiction should not be denied because its appeal stems from the Intermediary's use of flawed data contained in its own PS&R; that is, Intermediary data that did not contain the correct number of Medicare discharges and patient days (See, Provider correspondence dated July 25, 2006, in response to Board inquiry). In effect, the Provider asserts that it was required to use the Intermediary's Medicare managed care data to prepare its cost report and that its appeal rights should therefore be upheld. The Board disagrees with the Provider's representation. Instructions for preparing Medicare cost reporting forms contained in CMS Pub. 15-2 require all providers to complete and submit a Provider Cost Report Questionnaire, Form CMS-339. Section 1102.3 K of the questionnaire explains that providers may use the PS&R as the source document to complete their cost reports or that they may use their own internal records.

Based upon the merits of E.W. Sparrow Hospital's appeal, the Board majority finds that the Balanced Budget Act of 1997 provided for IME and DGME payments for services provided under risk health maintenance organization (HMO) contracts that had not previously been available. The Secretary of the Department of Health and Human Services (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.

Therefore, the question to be decided is what conditions precedent must be satisfied to entitle a hospital to payment for the new additional benefit. Prior to the BBA '97, whether a "claim" (described elsewhere as a form UB-92) was required to be filed for each patient stay 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 the BBA '97, in order to receive payment for the services furnished to Medicare beneficiaries, the hospital filed its claim for payment directly with the 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 Board majority finds that the claims in question were for services furnished by and paid for by Medicare + Choice organizations or other Medicare risk plans, and therefore, they 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 Balanced Budget Act of 1997 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. 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 Board majority finds that 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 a 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 the BBA '97, specifically, for the issue in question by the effective date of January 1, 1998, CMS should have followed the Administrative Procedures Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from January 1, 1998 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. For these reasons, the Board majority finds that the Intermediary's disallowance of the

subject Medicare managed care discharges/patient days, based on the fact that the Provider did not bill and the data was not captured on the PS&R, is without basis.

Finally, the Board majority is unpersuaded by the Intermediary's argument that a claim filed in UB-92 format is essential to determining a proper payment amount. 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. The Provider has the information necessary for the Intermediary to pay the Provider the IME and DGME amounts to which it is entitled.[10] The case must be remanded to the Intermediary to complete the audit of this data.

DECISION AND ORDER:

The Board does not have jurisdiction over St. Lawrence Mercy Hospital's challenge and it is, therefore, dismissed from the case.

E.W. Sparrow Hospital is entitled to receive additional IME and DGME payments for Medicare managed care enrollees for its fiscal years ended December 31, 1998 and 1999. The case is remanded to the Intermediary to include the days applicable to the Medicare + Choice enrollees.

Board Members Participating:

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

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: February 12, 2008

[10] Provider's Position Paper at 3. Provider's Supplemental Position Paper at 6. Tr. at 33-35.

Dissenting Opinion of Elaine Crews Powell

The majority asserted jurisdiction over the Medicare + Choice (M+C) discharges/days that E. W. Sparrow Hospital failed to claim on its as-filed cost reports for the years in issue. I dissent.

I find support for my position in the Medicare statute that governs the Provider Reimbursement Review Board, SSA 1878(d), which reads as follows:

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters **covered by such cost report** (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination. (Emphasis added)

Since no statute, regulation or program instruction prevented the Provider from seeking reimbursement for the additional IME and GME costs related to its M+C patients, I find that its failure to do so results in the unclaimed discharges/days not being "covered by the cost reports" in issue. The Board and Courts have come to a similar conclusion in several other cases.[11] Furthermore, allowing a provider to first assert its claim for reimbursement through the appeal process renders meaningless the Program's requirement that accurate cost reports be filed timely, because it effectively results in leaving cost reports open well past the deadline for their submission.

Despite my jurisdictional finding, I will, nevertheless, orate regarding the facts in this case in order to make my position on the substantive issue clear for the reviewers of the majority's decision.

The majority found that the Intermediary improperly excluded some of the Provider's Medicare managed care discharges/days from the calculation of additional IME and GME reimbursement authorized by §§ 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

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[11] See, Maple Crest Care Center, PRRB Decision 2003-D4 (November 7, 2002); dec'd. rev. CMS Admr. (January 9, 2003), wherein the Board denied jurisdiction over unclaimed bad debts citing Little Company of Mary Hospital Health Care Centers v. Shalala, 24 F.3d 993 (7th Cir. 1994.). See also, Athens Community Hospital v. Schweiker, 743 F.2d 1 (9th Cir. 1984); Battle Health Services v. Leavitt, 498 F.3d 401 (6th Cir. 2007).

were not exempt from submission to the Intermediary pursuant to 42 C.F.R. § 424.30 and that these claims were not **claims 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; 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 via a final rule published on August 29, 1997 (See, 62 Fed. Reg. 45565, 45968-45969). 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. Nothing in the record indicates that this process was not in place at the Provider's intermediary.

The Provider maintains that it did not receive timely notice of the requirement to file the specially coded UB-92 claim forms, but there is uncontroverted evidence in the record demonstrating that the Provider had definitive notice of the requirement as early as March 11, 1999.[12] While the Intermediary was unable to prove with contemporaneous documentation that it specifically notified Sparrow of the billing requirement before that date, I find credible the Intermediary witness's testimony[13] that she discussed the billing requirement with the Provider's staff prior to the March 1999 Medicare Memo, that Provider's staff person responded that the hospital was in the process of merging with St. Lawrence Hospital and decided not to bill because other priorities took precedence.

The record shows that the Provider, in fact, billed 17 days for services rendered in FYE 12/31/98 and 967 days in the FYE 12/31/99. Evidence of these billings is reflected in the Intermediary's PS&R which led to positive adjustments being made to the Provider's cost reports. The Provider now seeks to claim additional, unbilled M+C days of 3,406 for FYE 12/31/98 and 3,725 for FYE 12/31/99 and maintains that it can compute accurate payment of additional IME costs based on its internal records of the DRGs it assigned to

[12] See, Intermediary Exhibit I-2 - United Government Services' Medicare Memo dated March 11, 1999.
[13] Tr. pgs. 58-59 and 90.

the inpatient stays of M+C patients.[14] I agree with the Intermediary's contention that reimbursement of unprocessed claims cannot result in accurate payment because the pricer program for the FYEs in issue has been purged from claims payment system.[15] The evidence shows that the Provider eventually submitted claims for the additional IME and GME reimbursement after the claims filing deadline had passed. The Intermediary rejected these claims as untimely.[16]

To the extent that the Provider ignored the Program's claims filing requirement, it did so to its detriment. Its numerous arguments are, at bottom, aimed at shifting the burden for ensuring accurate IME and GME reimbursement 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 could be secured – the timely filing of properly coded UB-92 claim forms.

The Intermediary's refusal to compute the additional IME and GME reimbursement through the cost report using the Provider's internal logs as well as the rejection of untimely filed M+C claims was proper.

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Elaine Crews Powell, CPA

[14] Tr. pgs. 49-51, 75. The Provider's calculation of the amount in controversy for IME was based on an "average" DRG associated with discharges of M+C enrollees and it used the 2005 pricer program to cost out its claims.
[15] Tr. pgs. 72-73.
[16] Tr. pgs. 47-48.