PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D26

PROVIDER –
Loma Linda University Medical Center
Loma Linda, California

Provider No.: 05-0327

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC - CA
(n/k/a National Government Services,
LLC-CA)

DATE OF HEARING –
February 16, 2006

Cost Reporting Periods Ended –
December 31, 1998; December 31, 1999
and December 31, 2000

CASE NOs.:
02-0326, 03-0730 and 04-1130

INDEX

ISSUE:

Whether the payment for indirect medical education (IME) and direct graduate medical education (DGME) was understated because not all managed care days and discharges for inpatient services for Medicare beneficiaries were included in the calculation.

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).

CMS implemented the regulation by issuing Program Memorandum (Intermediaries), HCFA Pub. 60A Transmittal No. A-98-21, July 1, 1998: Graduate medical education payments. Exhibit P-157.

The filing of claims for Part A and B services is subject to time limits. The regulations provide the following.

> (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.
> (3) 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.

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

42 C.F.R. §424.44.

CMS has provided additional guidance concerning timeliness of filing claims in CMS Pub. 100-4. Section 70.7 provides for an exception if there is an "administrative error." Section 70.7.1 then provides several "standard" exceptions, including that "the failure resulted from excessive delay by Medicare, the FI, or the carrier in furnishing information necessary for the filing of the claim."

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Loma Linda University Medical Center (the Provider) is a 789-bed general acute care hospital located in Loma Linda, California. During fiscal years ended December 31, 1998, 1999 and 2000, the Provider claimed an adjustment to its cost report for IME payments. United Government Services of California[2] (the Intermediary) rejected the Provider's claim asserting that the IME payment had to be made through the claims filing process. The Provider appealed the disallowance to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations.

During the fiscal years at issue 1998, 1999 and 2000, the Provider submitted claims for 10,032, 11,506 and 13,997 managed care days, respectively, in order to receive interim payments for IME for managed care enrollees. A review of its records in late 2002 and 2003 concerning an overpayment by the Intermediary to the Provider and its repayment revealed a large number of HMO claims that had never been billed. For FYs 1998, 1999 and 2000, the Provider identified 13,077, 9,467 and 6,615 days, respectively. Exhibits P-154-155. The Provider requested instructions from the Intermediary on how to handle these unbilled Medicare managed care claims on its cost report. Exhibit P-160.

On January 13, 2006, the Provider directed a request to both the Intermediary and CMS indicating good cause for asking that a waiver of lapsed time limits be granted to submit data demonstrating its entitlement to additional IME and DGME payments for Medicare managed care enrollees for the fiscal years in question. Exhibit P-153. In addition, the Provider submitted detailed lists of the Medicare managed care enrollees identified with their associated Diagnostic Related Group (DRG), DRG weight and DRG payment. The Provider proposed as an alternative that the Intermediary verify this data and use it to make an adjustment to the Provider's IME and DGME payments rather than having the Provider submit late claims. The Intermediary did not accept the alternative data submitted by the Provider asserting that the proper mechanism to submit the information was to file a timely claim.[3]

The Provider was represented by Frank P. Fedor, Esquire, of Murphy Austin Adams Schoenfeld LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

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[2] United Government Services is now known as National Government Services.

[3] Intermediary's Position Paper and Reply to Provider's Amended Final Position Paper on Unbilled Medicare Managed Care Claims at 5.

PARTIES' CONTENTIONS:

The Provider claims that there is no time limit for submitting claims because the regulation at 42 C.F.R. §424.44 only sets time limits for claims under Part A and Part B and this case pertains to Part C. Even if the Board finds that the regulation at 42 C.F.R. §424.44 does apply, the Provider asserts that there is good cause to waive the time limit because defective instructions caused confusion with regard to what to do with claims from January 1 through June 30, 1998 and the billing process is defective because there is no mandatory mechanism to provide Health Insurance Claim (HIC) numbers needed for providers to bill for IME.

The Secretary did not require the enrollees to present their HIC number upon admission to a hospital if they had enrolled with a Medicare managed care plan. Without this directive, it is an unreasonable departure from the industry's customary claims process and creates a materially defective process. The Intermediary should allow the Provider to use alternative data, and its refusal to do so is a violation of the Administrative Procedure Act (APA) under which the court may set aside the Secretary's determination as arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. See, 5 U.S.C. §706(2)(A).

The Provider seeks a ruling that the Intermediary and the Secretary must accept data that the Provider submits and the Intermediary verifies that demonstrates entitlement to payments for FYs 1998 through 2000.

The Provider also claims that it is entitled to additional time to file its claim, under the regulations at 42 C.F.R. §424.44(b) and manual provisions at CMS Pub. 100-4, Section 70.7, because it's failure to meet the deadline was caused by error, misrepresentation and excessive delay by CMS. The Provider furnished a detail explanation of its position that the method used to implement the payment for GME was inadequate;[4] however, the Intermediary did not believe it justified extending the claim filing deadlines.

The Intermediary points out that the Provider received some notice of the requirements as evidenced by its processing a significant number of claims for payment which the Intermediary paid. The Intermediary states that the standard claim format which would adjudicate whether the claim belongs in the calculation is a reasonable way to implement the requirements of BBA '97 and there is no good cause shown to extend the deadlines for filing.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board addressed this issue in two recent decisions: Santa Barbara Cottage Hospital v. Blue Cross Blue Shield Association/National Government Services, PRRB Dec. No.

[4] Provider Exhibit P-153.

2007-D78, September 28, 2007, Medicare & Medicaid Guide (CCH) ¶81,789, aff'd in part and rev'd in part, CMS Administrator, November 16, 2007 (reversed on GME issue) and Bayfront Medical Center v. Blue Cross Blue Shield Association/First Coast Service Options, Inc., PRRB Dec. No. 2008-D3, October 12, 2007, rev'd, CMS Administrator, December 10, 2007. In both cases, the Board majority found that CMS did not make a change to the regulation at 42 C.F.R. §424.30 that exempts filing a claim with the Intermediary if the payment arises from services furnished on a capitation basis. Therefore, providers could not be required to file a separate claim for IME/DGME payments with the intermediary. Rather, providers could claim GME payment by providing other documentation that these services were provided. The same rationale is applicable to the instant case. The Intermediary must review the alternative documentation that the Provider presented and, if verified, use it as a basis to approve payment for GME services. In addition, the Board majority finds that even if CMS had properly implemented the claims mechanism for the GME payment for HMO enrollees, problems with the implementation constitutes good cause to grant providers an exception for late filing of claims.

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. Section 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.

Section 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 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]. (emphasis added)

42 C.F.R. §424.32 et seq. furnishes more detail including the "basic requirements" for filing all claims. The claim must 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 its 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 data 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 from Providers 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. 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.

Even if the Board had found that CMS could implement the claims requirement without regulatory change, the Board majority agrees with the Provider that it would be entitled to an exception to the deadlines for filing claims for two reasons.

First, the instructions were misleading. 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 Procedure Act (APA) prescribed "informal rulemaking" process and made provisions to handle the period from 1/1/98 until the finalization of the rule. The instructions were confusing as to whether the Provider could submit claims before June 30, 1998. The instructions were also confusing in that the Administrative Bulletin issued by the Intermediary on July 13, 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; it failed to mention DGME. Further, it did not specify a definite date when this billing should begin or make any reference to PM A-98-21 for further guidance.[5] Nowhere does the Board majority find a directive to the Provider that states that in order to receive IME and DGME supplemental payments the provider must bill the Intermediary. The Administrative Bulletin simply states that you 'may' bill.

Second, the Board finds that the process established by CMS had a significant error in that providers were required to submit a HIC number to claim reimbursement but that no effective mechanism or methodology was established to allow providers to obtain HIC numbers by requiring patients, HMOs or the Intermediary to provide the HIC numbers to providers. The Board finds that the Provider should be entitled to resubmit its claims for all three fiscal years in question once a mechanism is established by which it can obtain HIC numbers needed for the claims process. 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 improper and the case must be remanded to Intermediary to complete the audit and allow additional payment.

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 ended December 31, 1998, December 31, 1999, and December 31, 2000. The Intermediary's adjustments are reversed and the cost

[5] See, Provider Exhibit P-158.

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)
Yvette C. Hayes

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: May 9, 2008

Dissenting Opinion of Elaine Crews Powell

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

CMS is charged with the responsibility of ensuring proper program payments to providers of service. To accomplish this mandate, CMS employs various vehicles and processes such as the issuance of regulations and manual instructions as well as program memoranda. CMS notified intermediaries and the public regarding the added payments for Medicare managed care enrollees when it formally modified the IME and GME regulations 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.

The additional IME and GME payment for Medicare managed care days/discharges was effective for portions of cost reporting periods beginning on or after January 1, 1998, and Transmittal No. A-98-21 was issued by CMS on July 1, 1998. Therefore, teaching hospitals had adequate time to comply with CMS' instructions regarding the submission of the specially coded UB-92 claim forms. See, 42 C.F.R. §424.44.

Regarding the necessity of filing claims, regulation 42 C.F.R. §424.30 states in relevant part:

> [c]laims must be filed in all cases except when services are furnished on a prepaid capitation basis by a health maintenance organization (HMO), a competitive medical plan (CMP), or a health care prepayment plan (HCCP). (Emphasis added.)

Based on the above regulation, I find that the regulatory exception for filing claims does not apply to the specially coded UB-92s required for payment of the additional IME and GME reimbursement because they were claims for additional reimbursement for the hospitals' costs associated with being teaching hospitals and not for services furnished by any of the aforementioned health plans on a prepaid capitation basis. Therefore, I find that the claims in issue were "claims for payment" of the additional teaching costs[6] and that they were required to be filed within the time limitations set forth at 42 C.F.R. §424.44.

[6] In Saint Anthony's Health Center v. Blue Cross Blue Shield Association/AdminiStar Federal Illinois, PRRB Dec. No. 2006-D22, May 25, 2006, rev'd. CMS Administrator, July 19, 2006, the Board held that the time limitations for filing claims contained in 42 C.F.R. §424.30 did not apply to HMO claims. I distinguish my findings in Saint Anthony's from that in the instant case by the fact that the argument in Saint Anthony's pertained to the submission of HMO "encounter data" as opposed to the submission of specially coded UB-92 billing forms which I find are "claims for payment" and are, therefore, subject to the claim timeliness requirement.

Contrary to the 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 that the additional reimbursement reach teaching hospitals as soon as possible. I find that the use of a transmittal was a well established, efficient way of doing so.

Unlike similar cases where providers have alleged lack of notice of the billing requirement, it is undisputed in this case that Loma Linda was aware of this requirement. During the three years at issue, the Provider filed tens of thousands of the required UB-92s to claim the additional IME and GME reimbursement, and it received payment for those claims. I am puzzled by the Provider's contention that the Transmittal's instructions were defective and confusing given the Provider's ability to successfully bill and receive payment for so many of the required claims.

The Provider argues that, through no fault of its own, it failed to bill for 13,077 Medicare managed care days for 1998, 9,467 for 1999 and 6,615 for 2000. According to the record, however, these additional days were identified in late 2002 when the Provider hired a consultant. His work revealed a large discrepancy between the Provider's record of managed care volume and the number of days that appeared on the PS&R. (Tr. 109) In February 2003, the Provider inquired about whether the unbilled claims for 2000 could be reimbursed through the cost report (Exhibit P-160), and the Intermediary responded that the claims were required to be billed. The Intermediary also surfaced the claims timeliness issue. CMS then became involved, and in an email to the Provider's consultant, advised that the claims were to be treated as regular Medicare claims and that the timeliness standard applied.

The Provider maintains that one of the reasons that it could not bill some its claims was that the HIC number for Medicare managed care enrollees was not readily available. However the record shows that the Provider also failed to file claims for which it had the HIC number. (Tr. 134) The Provider's witness was unable to explain why this occurred. Therefore, I find that the Provider failed to establish an internal process that ensured that all of the specially coded UB-92s were filed in accordance with CMS' instructions.

The data used to calculate the IME and GME payments for regular Medicare patients is processed by the claims payment system and captured on the PS&R. Therefore, I find that it was reasonable to include the additional claims data for the Medicare managed care patients in the same claims processing system to ensure proper processing of the claims and accurate payment of the additional reimbursement due.

In summary, I find that:

- the issuance of Transmittal A-98-21 was a proper means of implementing the regulation requiring that additional IME and GME payments be made to teaching hospitals for manage care enrollees;
- it was unnecessary for CMS to issue a new regulation with notice and comment period;

- the specially coded UB-92 claims were not exempt from the timely filing deadlines under 42 C.F.R. §424.30;
- the Intermediary's refusal to accept UB-92s claim forms after the filing deadline prescribed by 42 C.F.R. §424.44 was proper; and
- payment of the additional reimbursement cannot be made through the cost report.

Elaine Crews Powell, CPA